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ABSTRACT

A health specialist working in a program providing health, social, and educational services to low-income children and families implemented and evaluated a practicum intervention designed to increase inner-city mothers' knowledge of the importance of ongoing prenatal care throughout pregnancy and to improve the mothers' health. A prenatal education and support program was developed. The program operated for 1.5 hours bimonthly for 8 months. A series of 15 sessions was conducted by medical professionals and educators. It was expected that all pregnant participants would: (1) learn more about prenatal care; (2) recognize wholesome, nutritious foods, as opposed to junk foods; (3) follow physicians' orders; (4) be weighed and have their blood pressure taken at each prenatal support session; (5) deliver full-term infants weighing a minimum of 5.5 pounds in 18 of 25 cases; and (6) have positive attitudes toward pregnancy. At the end of the practicum, 19 of 20 babies were born full-term and weighing at least 5.5 pounds. One infant was pre-term and delivered by caesarean section at 1 pound, 3 ounces. Related materials, comprising half the document, such as nutrition assessments and handouts in English and Spanish, logs and evaluation instruments, summaries of sessions, and a list of prenatal educational films, are appended. (Contains 30 references) (RH)

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Prenatal Support to Educate and Counsel Pregnant Mothers with Children in a Preschool Program

By

Sarah L. Mack

Cluster #28

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A Practicum II Report presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education.

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PRACTICUM APPROVAL SHEET

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This practicum report was submitted by Sarah L. Mack under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in the partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

Date of Final
Approval of Report

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ABSTRACT

Prenatal Education and Support Program (PES) for inner-city parents who have children enrolled in a preschool program.
Sarah L. Mack, 1990: Practicum Report, Nova University Ed.D. Program in Early and Middle Childhood.
Descriptors: Twenty-five Low Socioeconomic Participants / Nutritionists / Nurses / Teachers / Attorney / OB/GYN Doctor / Medical Assistants / Nutrition Written Assessment / Health Posters / Tour of the Labor, Delivery, and Neonatal Intensive Care Units in a Large Metropolitan Health Facility / Pre-term Infants / Telephone Calls / Written Notices / Written Summary of the Sessions / Transportation / Spanish Translator / Door Prizes / Cash Donations / Baby's Sweater Sets Contribution / Donations from Businesses, Individuals, Charitable Organizations, Church Groups, and Sororities / Attendance Records / Logs to Record Pregnancy, Labor, and Delivery Complications, Blood Pressures and Weights / 15 Education and Support Sessions / Home Visits / Record of Babies' Birth Weights, Full-term or Pre-term / Camera / Photo Album / Evaluations.

The problem addressed was that many women became pregnant in the Head Start program for the second, third, or more times and had received no or inadequate prenatal care. Many lacked the understanding of what constituted early, continuous, and quality prenatal care. Some of the expectant women failed to see the relationship between adequate prenatal care and pregnancy outcome.

The PES Program operated for 1 1/2 hours bi-monthly for 8 months. A series of 15 sessions was conducted by medical professionals and educators. Food and gifts for the women and their unborn infants were used as incentives along with a cash donation of $20.00 given to each woman after delivery if she had attended a minimum of one session per month. At each session, the women's blood pressures and weights were taken. Medical and social referrals were made as the need arose.

At the conclusion of this report, 19 of the 20 babies were born weighing at least 5.5 pounds. One infant was born pre-term because the mother experienced medical complications beyond early medical intervention. The infants' mean weight = 6.9 lbs., standard deviation = 1.68 lbs. and *t*-value = 3.76. These results indicate that babies born to low-income women who are involved in an ongoing prenatal program designed to provide education and support while pregnant can usually give birth to babies statistically above the "norm" of 5.5 pounds.

CHAPTER I

INTRODUCTION

Description of Community

The writer worked in a large program that provided health, social, and educational services to low-income children and families. The program was founded in 1965. It was located in a large midwestern urban area. The community's poor housing units, public schools, grocery stores, and other buildings reflected the disadvantages of the area's residents. There were two leading universities in the community, approximately five miles apart. One was a state university and the other a well-known private university and medical school. The state university was located in the center of the inner city. Its high towers and beautifully designed buildings did not reflect the surrounding poverty. There were three hospitals, hospital clinics, and several other health facilities. The diversified minorities were a mixture of Black, Caucasian, Spanish American, and other groups.

Writer's Work Setting and Role

The program serviced 770 children. It was specifically designed to combat the War on Poverty by helping economically disadvantaged families and children 3 through 5 years old to achieve their maximum potential. The program was family oriented and focused on comprehensive health, nutrition, education, and social services. The half-day preschool sessions were conducted in 20 local churches, housing projects, and synagogues. The children attended the sessions 10 months out of a year. The program strongly emphasized preventive health habits for all parents and their children.

Given the geographical location of the program and the economic status of disadvantaged families, emphasis was on the urban population. Many of the 770 mothers in the program were expecting their second or third child. The mothers' age range was between 18 and 34.

The writer's work setting had a number of levels. There was a clear-cut hierarchical differentiation of roles and functions, from the program director to the janitorial staff. All the employees and community volunteers were professionals or paraprofessionals. They all demonstrated dedication and interest in the performance of their assigned positions. Those who worked directly with the families and their children were sensitive to their needs and cultural differences. Also, the staff was knowledgeable regarding available community resources and contact persons.

The professionals comprised the administrative staff, teachers of early childhood education, parent counselors, and community volunteers. The administrative staff included a program director with a master's degree in social work; an education director who had a bachelor's degree in special education; two supervising teachers who held 2-year degrees in early childhood education; the writer, the health specialist for the entire program, who is a registered nurse and has a master's degree in human services; a medical assistant, who was a licensed practical nurse; van drivers; and volunteers who matched the program's funds with services in-kind.

At the 20 preschool sites, there were 42 teachers whose educational backgrounds ranged from a 2-year associate degree to a 4-year degree in education. Twenty parent counselors worked closely with parents, and had frequent access to them as they accompanied their children to and from the preschool centers. The parent counselors assisted the parents in obtaining needed health and social services. They worked closely with the writer.

The paraprofessionals were child care workers who had attended a vocational school for 6 months. Their curriculum covered early childhood education, childhood illnesses, first aid, and safety. They worked under the supervision of teachers in the centers. Since the program emphasized parental involvement, education, and early childhood training, the implied goal was to improve the standard of living for the whole family, including the unborn children.

The writer was highly qualified to supervise the program's health component. She is a registered nurse and a licensed and certified counselor; her title in the program was Health Specialist. She wore many hats. For instance, she coordinated all health services with the health clinics and other medical facilities for the children and families. All psychological screening, counseling, and referrals were scheduled and monitored by the writer. In addition, she reviewed all the children's health records before or soon after they were enrolled in the program. If more information was needed on a child or if a doctor's orders needed to be clarified, the writer served as a liaison between the providers and the parents, in many instances linking the child and family into an ongoing health care system.

The writer also wrote, reviewed, and monitored the health budget and planned and arranged for consultants and speakers to provide health inservices to staff, children, and parents. Because of her position, she was required to attend educational inservices, conferences, and workshops scheduled by the agency. Conversely, in accord with her level of expertise, she was also required to conduct conferences, workshops, and inservices on the local, state, and national levels. She was expected to develop and present health programs for parents, children, and staff and, whenever possible, the community at large.

The writer was responsible for writing and submitting the program's health reports, monthly, quarterly, and annually, to the local grantee office, who in turn disseminated the information to the regional and national program officials. In the middle of the school year, the writer served as a team leader of her component in the program's 5-day self-assessment. At its conclusion, all programmatic findings were compiled, tallied, and analyzed. According to the reported results, formative and summative, the writer planned health activities for the ensuing year.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The writer was convinced that infant mortality and morbidity reflected the preexisting health of expectant women and the medical care they received during pregnancy and delivery. Pregnant women who fail to receive adequate prenatal care place themselves and their unborn babies at high risk. This has been recognized by the U. S. Department of Health and Human Services' 1986 Report of the Secretary's Task Force on Black and Minority Health, which called for early and continuous prenatal care to ensure "healthy pregnancies, healthy babies." The report also noted the many social and economic factors associated with infant deaths and low birth weight.

Many of the expectant mothers in the writer's program became pregnant for the second or third time and received no or inadequate prenatal care. In her 15 years of experience working with an inner-city population, the writer has observed expectant women suffering from induced hypertension, excessive weight gain or loss, infectious diseases, the use of drugs, and malnutrition. The number of children in the program with handicapping conditions was increasing yearly. Those "In treatment + completed treatment + needing treatment" increased from 139 to 241 within one school year. The "high-risk" mothers were often unaware that they needed more services than usual. These should include medical screenings, nutrition supplements, and health education.

Their poverty was a major element in the lives of these women. Their primary objectives were centered on the basic needs. They focused on essentials such as food, housing, and caring for their families. These mothers struggled financially and emotionally from month to month. Their Medicaid checks were spent for food, rent, and other necessary items by the 3rd week in the month. Consequently, extra time and energy was spent obtaining food from hunger centers and neighboring churches. The writer can verify that such activities were carried out by the pregnant women in her program. These needs were considered more important than obtaining prenatal care.

Proper nutrition is essential for everyone, but particularly for pregnant women. The program's nutritional guidelines are issued by the US Department of Agriculture. "The Child and Family's Nutrition Assessment" conducted by the staff during intake provided an excellent history of family eating patterns. The writer observed that many of the expectant women in the preschool program displayed inappropriate diet habits. Their food intake included an excessive amount of "junk" food (see Table 1). Inadequate and improper food intake in pregnant women takes place at a time when nutritional requirements are high per unit of body weight and especially in the first trimester.

The writer observed six expectant mothers consume unwholesome food in the early morning. None of the food was conducive to the health of their bodies or those of their unborn children.

Table 1.

Writer's Observation of Six Pregnant Women's Early A.M. Dietary Intake

Over-the-counter drug *	Soda pop	Cookies	Donuts	Potato chips	Fruit punch	Smoking
1	1	1	1	1	1	1
1	1			1	1	1
		1	1		1	
1			1			
	1	1	1		1	
1				1		1

* Because of "not feeling well."

Another problem was the expectant mothers' use of illegal drugs. Many of them attempted to escape through fantasy into an environment of serenity. They viewed the drugs as a means of coping with problems and situations that seemed endless. When the center staff reported that an expectant mother was suspected of using drugs or consuming alcoholic beverages, seldom was anything done. The writer and other administrative staff agreed that it is difficult to accuse an individual of using drugs without accurate proof.

In the preschool program, mothers were never confronted about their suspected drug or alcohol habits, even when they were pregnant. One major reason was fear on the part of the staff. A second was fear that the mother would become hostile if she were accused of being chemically dependent, and would highly likely withdraw the child from the program. The rationale was that as long as the child remained in the program, there was always the possibility of helping the mother and the child to overcome a debilitating lifestyle. But year after year, preschool children were enrolled in the writer's program with diagnoses associated with substance abuse. Among these were fetal alcohol syndrome, twitching, short attention span, learning disabilities, and retardation.

Problem Documentation

There was indisputable and abundant evidence that the problem was real. The children's health records revealed evidence of pregnancy and birth complications for both mothers and babies. Four sample records showed the following: mother #1 had induced hypertension and severe anemia. Her baby was born prematurely, 3 weeks early, and weighed 4 pounds 2 ounces; it had poor appetite. Mother #2 was diagnosed with fibroid tumors and had a long hospitalization. Her baby weighed 4 pounds 9 ounces and had poor sucking reflexes. Mother #3 received no prenatal care until she was 6 months pregnant; although she had no prenatal problems or complications, her baby weighed 4 pounds 14 ounces. Mother #4 had induced hypertension and anemia. Her infant had multiproblems: because of respiratory difficulty, it stopped breathing for a short while after birth, and was reported as having seizures.

In a local newspaper, Grande (1989) reported statistics cited by Congressional Representative Louis Stokes at a meeting in Washington, DC, which was repeated in the writer's state. Prematurity and low birth weight in black babies are double the rate in white babies, with the gap increasing. In addition, pregnancy and delivery are more life-threatening for black women; ectopic pregnancy rates, for instance, are about 50% higher for black women, and mortality from ectopic pregnancies is 600% higher. Grande cited a State Department of Health spokesman who said that this state has rates similar to the national average.

The data below were reported for the metropolitan area of the writer's city.

Table 2.

State Infant Mortality Rates, 1970-1982

Area and race	Deaths				Fatal deaths	
	Under 1 year		Under 28 days			
	Number	Rate	Number	Rate	Number	Ratio
Urban places	993	12.1	646	7.9	647	7.9
White	614	10.3	400	6.7	421	7.0
All other	379	17.0	246	11.1	226	10.2
Black	369	17.6	239	11.4	216	10.3

Note. From Vital Statistics of the United States (1986). Vol. 2 - Mortality Part B. U. S. Department of Health & Human Services Public Health Service. Centers for Disease Control. National Center for Health Statistics. Hyattsville, MD: 1988. DHHS Publication No. (PHS)88-1114. U.S. Government Printing Office, Washington, DC.

In the writer's state, the birth rates continue to increase, but there is some slow improvement in the prenatal care received by pregnant women.

Table 3.

Prenatal Care Related to Low Birth Weight and Infant Mortality

	1983	1984	1985	1986	1987
Births	21,108	20,947	21,014	21,154	21,418
Mothers receiving late prenatal care	22.5%	20.4%	18.7%	17.1%	18.2%
Low birth weights	8.3%	8.1%	7.9%	7.9%	7.9%
Infant mortality rate (per 1,000 live births)	12.1%	13.2%	11.7%	11.6%	11.3%

Note. From Building on Promises: The Legislative Factbook on Ohio's Children 1989/1990 (p. 58) by M. Real and M. E. Hopmann, 1989. Children's Defense Fund and the Junior League of Ohio.

There were numerous pregnant women in the targeted population of the writer's program who were financially disabled and had a limited education. In their attempt to conceal their deficiencies, they resisted anything that might infringe upon their culture, values, and beliefs. As a result, they did not realize the importance of continuous preventive health care and were often reluctant to seek it. Multiple pregnancies during adolescence often limited their opportunities to further their education academically and vocationally. As an example, a 24-year-old unmarried high school dropout in the preschool program was pregnant with her fifth child. The chances for this mother to attain a higher education, to seek employment, to supplement her present level of income, or to have a successful marriage were nil.

Many expectant women living in the urban community are unable to use available resources because they lack understanding of the intricate and numerous structural barriers. Health information depends on social networks, but the stigma of being economically disadvantaged leads to low social confidence, preventing women from easily utilizing clinic facilities. In the inner city, lower socioeconomic minorities are usually ethnocentric and isolated from influences that are available to their middle- and upper-class counterparts. A structural barrier also exists between the attitudes of medical personnel and the consumer, which can become a major deterrent for the disadvantaged.

Causative Analysis

Many of the mothers with children in the writer's program were pregnant for the second or third time. The target population included a large number of women who were unmarried but sexually active, and there were many unintended pregnancies. Given their ages, their first pregnancy must have occurred during adolescence. Pregnant teenagers are more likely to drop out of high school regardless of the provisions made for them to complete the 12th grade and perhaps learn a vocation. Thus, they stunt their physical, psychological, intellectual, and social growth. They lack guidance and motivation, and fail to learn self-help skills. They are out of touch with available community services. Many of them do not know that pregnancy has special health requirements. Those who do have no clear conception of what constitutes adequate prenatal and postnatal care, nor a well-balanced diet and how this changes during pregnancy. They are also unaware of possible medical complications for themselves or their unborn babies.

The lack of education often leads to low employability and poverty; many of them are dependent on public assistance. The writer can verify that these mothers struggled financially and emotionally from month to month at great expense of their limited time and energy resources. Basic survival required such a high level of complexity that it was difficult to deal realistically and effectively with the extra requirements of pregnancy. Prenatal care therefore has a low priority. Moleti (1988) reported that poverty or near-poverty puts pregnant women into a "socially high-risk" category. Those women who see their pregnancies from a negative point of view often delay prenatal care while they are trying to accept their condition or to decide whether to have an abortion. Their ambivalence contributes to their not seeking maternity care.

There are great gaps in the delivery of prenatal care in the inner city. Brown (1989) pointed out that there are not enough maternal health clinics in all urban communities, although the poverty population is increasing. The writer knows from her own experience that the health delivery system is not easily accessible. It is common for a pregnant woman, accompanied by two small children, to need three buses to arrive at the clinic; often, even that is precluded by lack of transportation or carfare.

The system also has inadequate capacity within those facilities that do exist. There is a shortage of staff to provide adequate services to the poor. Sylvester (1989), Brown (1989), and Schwartz (1989) all concurred that there is an insufficient number of doctors; the writer has seen doctors and nurses each doing the work of several people. Sylvester noted that many obstetricians have resigned from obstetrics because of lawsuits and increased cost of malpractice liability insurance. Those who remain in practice are very selective of their clients; they tend to exclude high-risk deliveries, a category the disadvantaged fall into. It is self-evident that these shortages must lead to short tempers and poor communication with clients. For the pregnant woman, they contribute to long waits in unattractive, overcrowded, uncomfortable, and sometimes medically unsettling conditions.

Schwartz (1989) claimed that the health system actually perpetuates increased infant mortality and morbidity by offering less than quality service to the poor, that is, by offering care that is not as comprehensive as it should be. Moreover, the services are fragmented. In communication with the staff and administration at neighborhood facilities, the writer found a lack of coordination between the health and social service delivery systems. Women become discouraged when doctor's instructions, health education, a list of available resources, and other services are not presented as one interrelated unit. Often, they are not presented in the language of the client's culture, or on a level or in a form the disadvantaged can easily understand.

The health delivery system neglects to take into account the beliefs, values, knowledge, and lifestyles of their clients. For most women, their first experience will set their attitude in subsequent pregnancies. Provider attitudes to clients have a major effect on whether women will seek prenatal care (Brown, 1989). In some clinics, provider practices and policies are inappropriate and have a negative impact on women's decisions to use or not use health facilities during their pregnancy. Particular patterns of attitudes contribute to the underuse of established facilities.

The writer knows mothers in her program who resisted seeking medical care until absolutely necessary. Several women who were pregnant for the second time were in their late second trimester before they would see a doctor. Discussions with them made it clear that, combined with the traditional belief that prenatal care is not essential (Brown, 1989), negative treatment from the local clinic staff was a major reason. For the disadvantaged mother who already had an uphill struggle to keep her appointment, professional distance, inattention, or rudeness can be crushing.

Relationship of the Problem to the Literature

The infant mortality rate in the United States is increasingly dismal. It is higher in this country than in 20 other developed countries (Brown, 1989). Of the approximately 40,000 babies born annually, 1% die in their first year; about two-thirds of those deaths occur during the neonatal period (Schwartz, 1989). In data presented by Sylvester (1988), the writer's state ranked 28th in high mortality, and the city ranked 17th of those with greater than 500,000 population.

There are pronounced differences, however, between population subgroups. Brown (1989) stated that although there is a slow but continuous decrease in the infant mortality rate and in postnatal mortality, there is also a steady gap between the rates for black and white populations. Sylvester (1988) quoted a member of the Children's Defense Fund: a black infant "continues to be twice as likely to die before its first birthday."

It is generally recognized by the medical profession that infant mortality and morbidity are linked to low birth weight and prematurity. Rowe (1989) pointed out that babies born with low birth weights were 40 times more apt to die within the first 28 days of life. Those who manage to survive are twice as likely to have one or more handicapping conditions such as mental retardation, deafness, impaired vision, learning disabilities, delayed speech, autism, cerebral palsy, epilepsy, and respiratory conditions.

Nauta, Brush, Johnson, Affholter, and Hewett (1983) conducted a 6-month study in five states on babies born to mothers who received no prenatal care until they were 11.2 weeks into their pregnancy. Out of the 97 percent of the mothers who received periodic check-ups, 24 percent of the infants were born with medical handicapping conditions. Based on a self-reporting instrument, 25 percent of the mothers reported complications during their pregnancy; 17 percent reported multicomplications. The most frequent reported were: 14 percent with fluid retention, 10 percent with hypertension, and another 10 percent with prolonged labor or other related difficulties during delivery. Leveno, Cunningham, Roark, Nelson, and Williams (1988) and

Nauta et al. (1983) reported the most serious and common problems that contribute to complications during pregnancy: induced hypertension, preeclampsia, separation of the placenta, and prematurely ruptured membranes. Such complications are detrimental to the mother and the fetus, and lead to a high possibility of preterm labor.

The effect of nutrition during pregnancy is highly controversial. The variables are difficult to validate, since cells cannot be manipulated and damage in fetal brains cannot be easily measured during the 40-week gestation period. Some educators and medical professionals believe that the physical and organic causes of undeveloped organs are not related to nutrition. Others feel that poor nutrition during pregnancy must restrict fetal growth and development. Dobbing (1985) supported this view. He suggested that at some periods--especially in the first 20 weeks of gestation--there are spurts where growth of brain cells precedes that of other organs. During this period, the brain is more vulnerable than at other times. The adult number of neurons is developed during the first trimester. Mental and physical retardation can be associated with defects in the intricate sequences in the neuron's components. Any deficits that occur during this period cannot be easily corrected. Dobbing emphasized that nutritional deficits in the fetal stage are among the factors responsible for lack of brain growth and therefore restricted achievement in later life.

Metcoff et al. (1981) also stated that maternal nutrition is an essential regulator of fetal physical and intellectual growth and development along with many other variables. A prenatal clinic at the University of Oklahoma developed a maternal nutrition and fetal outcome project involving 725 women of at least 22 weeks' gestation. The hypothesis was (1) to develop a predictable correlation between fetal growth and prenatal nutrition, and (2) to establish strategies to prevent unfavorable outcomes for undernourished fetuses. This study provided data on malnutrition and imbalanced body chemistry in pregnancy. It was suggested that amino acid imbalance during pregnancy was associated with retarded fetal growth and intellectual development. The authors concluded that nutrition during pregnancy influences fetal growth in many ways and, controlling for nonnutritional factors, nutritional measurements at midpregnancy can be predictive of birth weight and other problems.

Several investigators examined the effect of substance abuse on perinatal morbidity and mortality. Cocaine use is increasing among pregnant women (Keith et al., 1989; and Smith, 1988), and the magnitude of the problem is becoming more widely known. Keith et al. cited its easy accessibility and relatively low cost in relation to similar drugs. Although the full implications are not known precisely, its use during pregnancy is closely associated with adverse pregnancy outcomes, and preliminary evidence suggests it is more hazardous for mother and infant than opiates, including heroin. The mother is susceptible to cardiac problems, utero placenta insufficiency, and premature labor and delivery. In addition, cocaine causes an impaired flow of oxygen to the fetal blood supply, fetal retardation, and reduced fetal growth and development. Keith et al. compared 137 drug-using women in Illinois with matched controls. Babies born to drug users had a significantly lower mean gestational age and birth weight. There was also more frequent antenatal hospitalization, preterm delivery, and abruptio placentae.

In one study of ten infants whose mothers abused cocaine, four were premature, three needed oxygen, and one was born after placental abruption. At 2 to 4 days, abnormalities were found in most of the infants (Ferriero, Wong, Townsend, and Simon, 1988). Smith (1988) reported that cocaine use by the pregnant mother places the unborn child in a high-risk category. In many instances, the fetus is spontaneously aborted during the first trimester of pregnancy. Infants born to women who used cocaine during their pregnancy were reported to have shorter stature, lower birth weight, and a smaller head circumference than infants born to nonusers. Ling and Boutle (1979) stated that children born to heroin-addicted mothers were reported to be functioning below average in school and have been diagnosed with neurologic and emotional disorders.

Smith (1988) asserted that cocaine abuse is not limited to low-income or uneducated women. She pointed out that the use of nonprescriptive drugs during pregnancy, including cocaine, can be attributed partly to limited maternal education about their impact on the unborn fetus. However, timely intervention may be difficult because cocaine addiction is not easily detectable.

Malinoski and Gressman (1986) implied that a comprehensive, coordinated maternal and child health care program, which included nutrition, was imperative for the well-being of both mother and baby. Hughes, Johnson, Simons, and Rosenbaum (1986) stated that, "one baby a day might have lived if its mother simply had received adequate prenatal care" (p. 17).

Senator Lawton Chiles of Florida contrasted preventive prenatal health care with expensive "rescue treatment" after a baby is born (Rowe, 1989). Prenatal care is not only essential but, unlike other systems, it is cost-effective when compared with the astronomical expense of a neonatal intensive care unit, which is the same whether the infant survives or dies (Healthy Mothers, Healthy Babies: A Compendium of Program Ideas for Serving Low-Income Women, 1986; Sylvester, 1988; Brown, 1989). Three dollars and thirty-eight cents is saved for each dollar spent on prenatal care (Brown, 1989); each low birth weight prevented saves the health care system $14-30,000.

Leveno et al., (1985) defined the criteria for predicting birth outcome. They stressed that a thorough prenatal examination includes a review of the mother's anatomy as related to pregnancy and delivery, the pregnancy education of the mother, and the prognosis for the infant. The risk factors for mothers (also cited by Malinoski and Gressman, 1986) were:

1. Prepregnancy medical conditions and inadequate nutritional history.
2. Age less than 18 or more than 35.
3. Minority race.
4. A history of many pregnancies in rapid succession.
5. Gestational age of fetus.
6. Pregnancy and delivery complications--for example, hazardous position of baby, excessive bleeding, toxemia, overprolonged labor.

Eighty-four percent of the 4,619 mothers in the study of Leveno et al. (1985) in a county hospital received prenatal care; 16% did not. The mortality rate for babies born with prenatal care was 16 per 1,000, and for those without, it was 73 per 1,000. The mean birth weight of the newborns was also higher for mothers who had received prenatal care. Both respiratory distress and intracranial hemorrhage were significantly higher for the group whose mothers had not received prenatal care. Many of the babies born with low birth weights had long-term or permanent handicapping conditions, and required frequent or prolonged hospitalization at enormous hospital expense. At 1 year of age, about one-third of the infants were diagnosed with neurological or developmental deficits.

Leech (1983) considered pregnancy needs over and above the medical aspects. She emphasized the importance of education that included medical terminology--for example, "episiotomy," "dilation," "contraction," "mucous plug," and "afterbirth." These terms are relevant to their pregnancy and are part of medical jargon, but women with low or average educational attainment are often unfamiliar with them, nor do they associate them with the dynamic changes occurring within their bodies. Leech stressed that an infant's future development was based on how well its survival needs are met. She maintained that health care goes beyond delivery, and must be continued once the baby goes into the home (including preventive care). Infants need to feel safe and loved, and these feelings are crucially related to any conflict that might surface among older children or other family members when the baby comes into the family.

Brown (1989) claimed that the large heterogeneous population and the pluralistic health system in this country negates comparison with small nations with greater social and economic stability and with a quality health system already in place. Donaldson and Billy (1984), however, conducted an international collaborative study of six countries selected because of their diversity. The major goal was to establish criteria for accurate maternity care, in order to assist health providers to analyze and manage the problems that confront them. Their evaluation measurements were based on recommendations of the American College of Obstetrics and Gynecology, and included many of those recommended by Leveno et al. (1985). They stressed the importance of the mother's nutritional intake. One of their crucial points was that the number of prenatal medical visits was significant for an infant's birth weight; they considered fewer than eight visits inadequate. They found that the number of visits correlated with educational level, and that eight or more prenatal visits were more compatible with a higher level of education. Those with less education often had only one visit to a doctor, and equally often it was only to confirm that they were pregnant. The investigators theorized that women with less education are more likely to adhere to traditional patterns of pregnancy.

Ames (1981) was concerned about inadequate maternal care in the rural areas of the state she studied. She considered that, on average, any fewer than 11 obstetric visits for a healthy pregnant woman were inadequate. Women who could afford to use private providers averaged about 15 visits. In poor rural areas of the state, where accessibility to public health care is difficult, 1,000 to

1,500 babies were born annually at home and delivered by untrained "granny" midwives or by trained midwives without accessible back-up medical facilities. It was concluded that poverty and poor pregnancy outcome are linked.

Brown (1989) discussed at length the lack of prenatal care for low-income populations. In 1986, 76% of the new infants in this country were born to mothers who had begun prenatal care in the first trimester, 18% had care delayed until the second trimester, and 4% waited until the third trimester. Two percent were born to mothers who had received no prenatal care at all. These figures are for the United States as a whole; for blacks, only 62% had first-trimester prenatal care, and 4% had none at all. Brown's analysis of trends showed that, since 1980, extending prenatal care to more segments of the population has, at best, stabilized; for black women, the rate of births with late or no prenatal care has increased. In 1986, 11% of births among black women were in this category.

Infant mortality seems to be inextricably linked to the two related socioeconomic factors of poverty and low educational level. Rowe (1989) quoted Rae Grad, Executive Director of the National Commission to Prevent Infant Mortality, who characterized infant mortality as not a medical problem but as a social problem with medical consequences. Rowe and Ducey et al. (1987) stated that improper health care and nutrition are frequently a result of an income insufficient to accommodate many of the essential needs (such as nutritious food), and more so during pregnancy. Ames (1981) noted that educational levels influence not only the ability to purchase medical care but also the incentive to seek it; although public health facilities are scarce in the state she studied, the use of those available was below the minimum needed.

Brown (1989) reviewed some of the attitudes that inhibit women from seeking prenatal care: unplanned or negative attitudes toward pregnancy; the belief that medical care is not important except when one is ill; the unwillingness to give up drugs and other habits that could be detrimental to expectant women and their unborn babies. She too found that poverty and lower levels of education were important risk factors.

Ling and Boutle (1979) noted that chemically dependent women have poor self-esteem. They characteristically do not care for themselves and have poor nutrition and lifestyle. Often, they do not see a doctor throughout the entire course of their pregnancy.

It has been argued that the poor fail to seek medical care or to comply with physicians' orders. Patient noncompliance in taking prescribed medications for diagnosed disorders is known to be generally low for all populations. Peck and King (1982) evaluated strategies used for increasing compliance. A major factor was poor communication between doctor and patient, and an initial negative attitude on both sides. The authors pointed out that patients are often disturbingly ignorant about their own physical conditions and prescribed medications, and frequently are unable to understand physicians' advice and instructions. Their reluctance could also be based on apprehension about taking drugs, fear of unpleasant side effects, and sometimes the necessity for a change in lifestyle or diet in order to take medication properly. Dissatisfaction with doctor-patient relationships and interactions, including the professional's attitude toward the patient, are major deterrents.

Most of the studies cited lack of finances as a major reason that women were not obtaining sufficient care. Community resources may be limited. They may be inaccessible and impractical for inner-city residents who lack transportation and child care (Schwartz, 1989).

But there are major system barriers as well. Brown (1989) characterized the American maternal health system as fragmented, flawed, and highly complex. There is sufficient, even overabundant, health care for the affluent, but it is scarce for the poor. In some areas, public maternal health care is unavailable; Ames (1981), for example, admitted that maternal health services are restricted in rural areas. Moreover, the care offered can be inadequate. Many women in Sylvester's study (1988) reported that the doctor's examination consisted of taking the client's blood pressure and giving her "a pat on the belly" (p. 56).

Healthy Mothers, Healthy Babies, a report issued by the U. S. Office for Maternal and Child Health Services in 1986, discussed five major U. S. cities, and noted that many women were unaware of the services that are available; others were deterred by their inconvenient location. Brown (1989) reviewed studies that drew on women's own perceptions of the obstacles. In two studies, 60% and 73%, respectively, of those who received no prenatal care had attempted to obtain it.

Other barriers cited by Brown (1989) were inconsistent clinic hours for the working poor, complex registration procedures, poor coordination among medical and social services and, above all, long waits at the clinic, which has been found to be a major barrier in virtually all the studies cited. Sylvester (1988) also cited these barriers, and noted too that the depressing atmosphere at clinics acts as a deterrent.

Brown (1989) indicated that in addition to the unavailability of facilities, there is a shortage of obstetricians because of their malpractice insurance rates, and frequent rejection of pregnant clients on Medicaid. Private providers are not obligated to serve Medicare recipients, and will accept only those who have insurance or money. This leaves out the poor.

Many poor pregnant women are not eligible for Medicaid but have little or no insurance to supplement a limited income. Carter (1986) reported the dilemma faced by the medically indigent when community services are cut off. A university hospital that had been the major provider for the community had to reduce its services because of increased costs. The emergency room then became the only port of entry for the poor or near-poor, and then only when a crisis had been reached. A survey of the target population revealed that about 300 women annually--approximately 10% of the resident pregnant women delivered in the county--were in a financial bind. Their mean age was 23. Typically, they were white, married and with other children, and had an 11th grade education. They were ineligible for Medicaid and had no or inadequate insurance, and could not afford prenatal care. These women were falling through the cracks in the system.

Rowe (1989) pointed out that Medicaid assists less than 40% of America's poor and about 50% of children living in poverty. Yet the U. S. poor population continues to grow. While the number of Americans living in poverty increased by 10.5 million between 1977 and 1983, the number of Medicaid recipients declined by 1.3 million. Carter (1986) noted that in 1985, fewer than half of all mothers and children were eligible for nutrition benefits through the Women, Infant, and Child (WIC) supplemental food program, and eight states served less than 30% of their own poverty population.

This lack of a good prenatal program for those in need reflects pervasive social and political attitudes. Sylvester (1988) noted first of all the difficulty in persuading people that the infant mortality statistics are real. In addition, this group has limited political impact; Sylvester quoted a leading advocate of prenatal care services as saying sadly, "poor pregnant women and infants don't vote much" (p. 50). Finally, there exists a prevailing attitude that blacks ought to stop reproducing.

The problem has been recognized by Congress. With the goal of producing healthy babies, it has set up the National Commission to Prevent Infant Mortality. Rowe (1989) cited its chairman, Senator Lawton Chiles of Florida, as calling for decent care and guidance for all pregnant women, with special efforts to reach those most at risk.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The development of a prenatal education and support (PES) program is essential to early, continuous, and quality maternal and infant care. It is imperative that inner city expectant women understand the importance of ongoing prenatal care throughout the course of pregnancy. The goal of the practicum was to develop that understanding, to ensure that "disadvantaged mothers and babies will be healthier."

Behavioral Objectives

An analysis of the literature revealed that inadequate prenatal care contributes to complications of pregnancy and developmental delay of newborns. However, many of the sources suggested strategies to help expectant women acquire knowledge of prenatal care and the complications that could result if recommended care is not adhered to.

To provide specific guidelines during the implementation of this practicum, seven measurable objectives were selected for their appropriateness. Each was related to and contingent upon the main goal. The following behavioral objectives were selected for this major practicum:

1. All pregnant participants will learn more about prenatal care.
2. All pregnant participants will recognize wholesome, nutritious foods, as opposed to junk foods.
3. All pregnant participants will follow physicians' orders.
4. All pregnant participants will be weighed each time they attend the prenatal support session.
5. All pregnant participants will have their blood pressure taken at each session.
6. Eighteen of 25 babies will be born full-term and weigh a minimum of 5.5 pounds.
7. Expectant mothers will have a positive attitude toward pregnancy.

Measurement of Objectives

The first objective was to be measured by an attendance list (see Appendix A). At each educational session all the attendees were to sign the attendance sheet, to allow a record of those who attended and those who were absent. For those who were absent, it would provide an opportunity to explore their reasons for not attending the session.

The second objective was to be measured by administering a 15-minute Pre- and Post-Nutrition Assessment of the four major food groups (milk, meat, bread, vegetable/fruit) (see Appendix B). This measurement was chosen to assess the participants' knowledge about nutrients in foods and beverages that should be consumed during pregnancy as opposed to junk foods. It would also serve as a dietary guideline to explore how the necessary nutrients can be obtained from culturally diverse diets.

The third objective was to be measured by records that reflected physicians' orders (see Appendix C), kept and unkept clinical appointments (see Appendix D), and complications that occurred during pregnancy (see Appendix E). The physicians' records would allow communication to be maintained between the medical staff and the writer when the participants needed help in understanding and adhering to medical orders.

The fourth objective was to be measured by a log of patients' weights which would indicate abnormal signs and symptoms (see Appendix F).

For the fifth objective blood pressure was to be measured bimonthly (see Appendix F) and serve as an indicator of medical problems. Hypertension (high blood pressure) is much more prevalent in black than in white women. Untreated high blood pressure can be harmful to the mother's and the fetus' health. During pregnancy, hypertension may develop rapidly in women with a history of high blood pressure but also in those who have no such history.

The sixth objective was to be measured by recording the birth of all infants born prematurely or full-term, and of their birth weights (see Appendix G). Infants born full-term, weighing 5.5 pounds or more and with normal anatomy, adjust easily to their new environment. Those born prematurely may be confronted with difficulties. Some of the medical problems may be permanent.

The evaluation tool for the seventh objective was to be a self-assessment by the participants after their delivery or at the end of the implementation period (see Appendix H). This would provide valuable feedback from the participants. The first five responses required a yes-or-no answer. The second group of five questions asked for required explanation and justification. Such a device can be useful in planning and improving performance standards for the PES sessions in the future.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

The literature provided a wealth of information for discussion and evaluation. The recommended strategies are considered practical, inexpensive, and realistic in promoting early, continuous, and quality prenatal care. Among those who contributed strategies were individuals in the fields of medicine, education, counseling, and nutrition.

Many authors recognized the importance of involving politicians and officials at all levels of government, since only those who control the power and the money can make positive changes in the health delivery system. Brown (1989) stated that strategies for solutions would be contingent upon public policy decision-making as reflected in an action plan. Addressing their responsibility to their constituents, she unequivocally referred to eliciting the aid of the United States President, Congress, and other national leaders. Brown went further; she believed that not only the politicians, but also public and private groups, health service agencies, and foundations should be educated to draw women into early prenatal care.

Public policy is often a result of political tradeoffs between those interest groups that have something to bargain with. It is not generally responsive to the needs of the targeted population, since individuals in this group are frequently unaware of how to influence the political system, and many of them are not voters. Therefore, they have no clout.

Sylvester (1988), too, believed that the involvement of politicians was essential, and that government action is needed across the board instead of in fragmented local efforts. Sylvester cited South Carolina's attempts to reduce infant mortality by expanding Medicaid eligibility, by reimbursing hospitals for indigent care, and by establishing a Resource Mothers Project that trained community women as support persons for pregnant teenagers. The infant mortality in the state dropped dramatically, particularly for nonwhites, the target group. In those aspects where the program failed, it was discovered that procedural red tape had been a major barrier to the pregnant women.

In the writer's opinion, prenatal care extends beyond routine visits to clinics. Strategies are needed for those who are on substance abuse or suffering maternal malnutrition. These were discussed at length in the literature.

Keith et al., (1989) established a medical regime model. They identified expectant women who had been targeted as being at high risk because of drug use. Keith et al. coordinated obstetric, gynecological, and psychiatric services with maternal care. The model allowed for psychosocial assessment, emotional support, and therapeutic intervention, and their plan of action included regular prenatal visits along with educational activities. The illegal use of chemical substances was monitored as closely as possible although, as this writer knows, it is not always easy to identify those who use drugs. This model seemed to have been effective for those who wanted help and were willing to enter and remain in the program. But it does not address those who don't admit their addiction, who are hard to reach, or who drift in and out of treatment programs, as so many users do.

Smith (1988) indicated that collaboration helped to ensure maximum and quality prenatal care to addicted mothers. Clients addicted to cocaine were referred to local cocaine treatment centers. All medical data and planning were shared with others involved in the treatment. In conjunction with prenatal care, emotional support was provided to encourage continuance in the program. Users were made aware of substance abuse treatment centers in the neighborhood and, for example, of the drug hotline telephone number. Smith emphasized that those concerned with treating drug users must be sensitive to the mothers' needs. They should be nonjudgmental and nonthreatening if they are to elicit honesty about addiction.

The writer knows from her own experience that it takes time to establish a trusting relationship and a workable rapport with individuals who are clinically dependent. Most addicts deny drug use, since they are afraid of being penalized or even prosecuted for their addiction.

Diet interacts with other factors to influence the outcome of pregnancy. Dobbing (1985) studied the effect of maternal nutrition on pregnant rats, and compared the rat brains to those of the human fetus in the last trimester. He concluded that nutrition and other environmental factors, as well as the health care of the pregnant women, affected infant growth and development in utero. He indicated that attacking poverty would raise the standard of living and enable the targeted population to afford better food during pregnancy.

Suitor, Gardner, and Feldstein (1990) developed a questionnaire to ascertain nutrient quality and food selection among a culturally diverse population of low socioeconomic-level pregnant women. They found that much of their food came from the WIC supplemental food program, which is available to low-income women during pregnancy and for a time afterward. The program provides such items as milk, eggs, cheese, juices, and approved cereals, and contains all the vitamins and nutrients needed by pregnant women. Suitor et al. concluded that variety of food is not important so long as the basic nutrient quality is there. They highly recommended the WIC program for pregnant women.

This writer has found that many women fail to maximize their use of WIC. The program is intended to be a supplement to the regular diet, not the core of it. It is meant to liberate the regular food budget so that a wider variety of nutritious food can be purchased. Instead, many women divert the money from their regular food budget into the purchase of non-nutritious or non-food items.

The writer agrees that the WIC program represents an excellent resource and, like many of the clients who use it, values its assistance. But many low income women are proud, and resent having to accept help from public programs. It would be more practical and realistic if the targeted population learned to access and affect the system:

A survey of more than 1,500 programs in maternal health for disadvantaged women was conducted by the Healthy Mothers, Healthy Babies Coalition (1986) to determine the major goals and strategies of these programs. A major strategy used was providing education along with resource materials. These women were often receptive to handouts and printed materials with clear, simple explanations of pregnancy. One of the findings was that pregnant women wanted the broadest possible range of information about all aspects of their pregnancies, and did not focus on one area more than others.

When its population's inadequate medical insurance coverage forced a local hospital to drastically reduce health services for the poor, concerned residents in the community reported by Carter (1986) called for other solutions. Local leaders in the obstetric clinic designed and developed a maternal-child health care program that included various community resources. Services were comprehensive and coordinated instead of fragmented. The program utilized professionals in other related disciplines. Women were referred to social services for financial or domestic problems, to nutritionists for malnutrition, and to other appropriate services where necessary. All expectant mothers were presented with an educational packet and a baby gift. They were also certified for the federal food supplement program. The program guided women through the system barriers from the beginning to the end of their pregnancy. With the collaboration and participation of the public and private sectors, health care was made accessible to expectant mothers and other indigent clients. Carter's proposed solutions resulted in an overall improvement in the clients' use of health services, and included an average increase of 92 percent in attendance for clinic appointments. A mortality rate of 12 decreased in 2 years to 11.7. The attitudes of medical staff also changed, as they became more receptive to the idea of accepting poverty-stricken clients.

Although the writer's program could not provide medical services directly, Carter's (1986) strategies were adapted for the practicum. Community leaders and concerned citizens made cash donations and contributions, and professionals provided free workshops. Clients received supplemental food programs, free preliminary packages of literature, and donated gifts.

A number of different strategies were presented in a Resource Mothers project that aimed at providing maximum maternal care for expectant mothers. Continuous classes in nutrition and prenatal care were presented. The funding allowed for women (themselves mothers) to be trained in prenatal education, counseling, social services, labor, and delivery. In essence, the trained staff became able to counsel pregnant women in all the circumstances of pregnancy and delivery. To insure transportation for the parents to and from the clinic, an outreach van was purchased. Planned transportation decreased the opportunity for excuses for unkept clinic appointments. The infant mortality rate decreased from 18.5 in 1978 to 13.2 in 1986; the morbidity rate for nonwhite babies was lowered from 26 to 17.9 during the same period. The program not only provided possible and workable solutions but also achieved a high degree of success, and has been replicated by other states (Sylvester, 1988).

Built into the writer's practicum were a variety of activities that were similar to those reported by Sylvester (1988). Professionals in various disciplines provided continuous education, counseling, and other needed services. The writer, like Sylvester, supplied outreach transportation to ensure easy accessibility to the bimonthly educational and counseling sessions.

Moleti (1988) emphasized that those who work with socially at-risk women must remain alert and sensitive to their needs and cultural differences, and encourage verbalization without judging. These workers need effective counseling skills, and must follow through on the promises they make (thus at the same time acting as role models by exemplifying responsible behavior). Interdisciplinary teams need to be harmonious and consistent with each other. Moleti notes that this targeted population has so many unmet needs that a request for help may often be expressed in inappropriate outburst behavior. Workers must realize that a socially and emotionally high-risk clientele needs as much intensive care as the physically high-risk, and requires diversified resources, intense participation, flexibility, and persistence.

The writer considered Moleti's (1988) approaches realistic and practical. Often, situational crises like unplanned pregnancy can contribute to dysfunctional behavior if the person lacks appropriate coping skills. Trained persons who are knowledgeable and sensitive to the needs and lifestyles of high-risk pregnant women can provide therapeutic services to both mothers and their unborn infants.

Brown (1989) indicated strategies for communication. Outreach programs can be developed to assist women in obtaining prenatal care, and social support services would encourage them to continue in it. Brown recommended that all cumbersome multi-page applications be reduced to a single page in simple language, and be easy to understand and complete. Provisions should also be made to have bilingual interpreters for clients who are non-English speaking. The news media should be used as a vehicle to communicate the location of clinics and other facilities, and can include the hours of operation. All health services listed in telephone directories should be in large bold print for ready identification. Telephones at the facilities need to be staffed adequately to avoid busy signals.

Like the writer, Brown (1989) has obviously known some applications for social assistance that have been as much as 35 pages long. She must also be aware that many low-income women do not have phones. They sometimes use a neighbor's phone, which inhibits their speaking freely and does not allow for confidentiality. Moreover, they cannot monopolize a public or a neighbor's phone, and do not themselves have the time for long waits. This writer concurred with all of Brown's suggestions, and the goals and objectives of her practicum were based on Brown's recommendations.

Description of Selected Solution

Prenatal care extends beyond routine medical visits to a doctor. Low-income pregnant women have numerous unmet needs--social, emotional, financial, and physical. Many are shy and sensitive, and have a sense of pride. Obviously, the writer cannot alter the system or the financial status of the clients. But there are other alternatives that can circumvent the barriers and are highly feasible, even with available resources, in assuring health care to all participants in the program.

The writer planned, developed, and conducted a pilot prenatal education and support program for 25 inner-city women, fashioned after several health and social programs such as those reported by Carter (1986), Sylvester (1989), and Brown (1989). It provided education, counseling, and social services, and was designed to be both accessible and affordable. It followed the women through their pregnancy, birth, and the first weeks at home. The program was conceived as an adjunct to the preschool program with which the writer is affiliated; it was administered through that program, used a preschool site, and drew on the preschool staff, which was kept informed at all points. The active staff for the PES consisted of a nurse and a graduate student counselor. The participants were mothers with children already enrolled in the preschool, who were referred by the center staff or by themselves.

The rationale for the solution selected was that learning about their pregnancies would make a difference for the mothers and therefore for the infants. The women would also learn how to gain access to other community resources. The emotional and practical support provided would enhance their self-image by enabling them to feel comfortable about what they were doing and how they were doing it. Above all, they would realize they were not alone in any aspect of their needs.

These were met in a variety of ways: through group and individual support, counseling, and referrals to community agencies. Attempts were made to ensure that maternal care was available, accessible, and affordable.

The PES system was built around the needs and lifestyles of the pregnant participants. The writer's district includes 20 preschool sites in widely separated communities; therefore, the PES site had to be centralized and easily accessible, and have space on the first floor so that the pregnant women would not have to go up and down stairs. Bus tickets were provided for those women who needed transportation. Since PES classes were held on the one weekday when the preschool was not in session, a separate space was needed for the children who accompanied the parents, and baby-sitting was provided. Food was served to the participants; thus, the site had to include cooking facilities approved by the Department of Health.

The program was based on structured education about pregnancy and maternal health, built on a broad base of social and practical support. It was designed to allow the women to gain information and perspective on their pregnancy as it progressed, while changes were taking place in their appearance and feelings. It was meant to stimulate their thought processes and appeal to their interest in the development and birth of a healthy, not an unhealthy, baby. It was also meant to teach the participants how to use the system.

At the core of the program were the biweekly sessions. Each one was designed to provide education in an area that affected the lives of pregnant women, with a recruited expert to discuss his or her area of expertise as it related to pregnancy. These professionals included nutritionists from the WIC and Mother and Infant (M & I) programs, obstetric/gynecological and pediatric physicians, a clinical psychologist, an early childhood educator, a dentist, an attorney, and a drug counselor.

The workshops made liberal use of handouts that summarized and reinforced the talks. Each mother received a list of all kinds of other assistance available in the community. Most of the handouts were translated into Spanish for those who were not English-speaking.

The sessions were primarily educational, but functioned also as occasions for socializing and support. Built in was a period of informal discussion among the group members, their significant others (who often unexpectedly accompanied them), and the speaker. This offered an opportunity to voice individual concerns and pressing problems, and to receive sound professional advice.

While maternal health was being discussed in the workshops, it was also being addressed in more concrete ways. Nutritious snacks and beverages were served to mothers and children at each session to provide a more relaxed atmosphere, but also to exemplify nutritious foods. The Pre- and Post-Nutrition Assessment tool allowed the participants to learn both flexibility and consistency while making choices from the four basic food groups. It was particularly useful in evaluating the women's learning of the number and quantity of servings needed. The writer anticipated that knowledge of nutrition during pregnancy would carry over into the regular diet after the baby's birth. In addition, this device aided in the purchase and preparation of food and beverages for the sessions.

Nurses monitored the mothers' blood pressure and weight at each session (see Appendix F), and checked for other medical problems (see Appendix E)--edema, vaginal bleeding, hypertension, excessive weight gain or loss, constipation, toxemia, and preeclampsia--so that these conditions could be reported to the participant's physician. This was another opportunity for informal counseling about maternal health or how to interpret what the doctor said. It would also be an appropriate moment to emphasize decreasing sodium in the diet. In an effort to respect territorial boundaries, the PES program made a strong attempt to enhance or augment existing community health services, not to compete with them.

Mothers entered the program as they became pregnant over the course of the 8-month practicum. Provisions were made to enable them to catch up on the earlier sessions they had missed.

The program was deliberately designed with a great deal of opportunity for individual counseling and dialogue; any concern found an ear. Keeping track of kept and unkept appointments was helpful because if the expectant women had problems maintaining scheduled appointments, the reasons could be discussed with possible solutions. Often, the writer served as a responsible role model. An outreach element helped the women to deal with other, outside problems in their lives. Incentives, individual reminders, and every other possible help was given to enable the women to stay in the program.

The program was funded by the George Gund Foundation for 1 year at $5,000, which covered the costs of professional speakers, transportation for the participants, baby-sitting, supplies, and food. Further contributions of time, money, or goods were made by local businesses, community leaders, church groups, and other agencies and organizations, and by individual volunteers.

The writer is convinced that education about prenatal care, following the physician's orders, eating properly, and feeling good about herself will have an impact on the mother's health and ultimately on the delivery of a full-term healthy baby weighing more than 5.5 pounds.

Report of Action Taken

A 1-year pilot program was developed and implemented by the writer and staff to provide prenatal education and counseling (PES) sessions to 25 inner-city pregnant women. Each session of the PES program was advertised throughout the community by fliers, using diagrams and pictures, and by word of mouth. The participants were referred by the center staff or by themselves. The main criteria for admission into the program were that the women must have a child enrolled in the preschool program and must be in the first or second trimester; the third trimester did not allow enough time for education. The group included Blacks, Caucasians, and Hispanic Americans, with an age range of 23 to 35. The number of children they had ranged from 1 to 7.

The sessions were conducted on a day that the preschool was not open; therefore, nonpregnant parents with children in the program were paid an hourly stipend for baby-sitting services during the sessions.

Each session was designed to last for 1 1/2 hours. They were scheduled in the afternoon from 1:00 to 2:30 P.M. This left the mornings free for parents to take care of their young children and/or get older children off to school, to pick up children who were attending a half-day kindergarten, and to keep WIC, ultrasound, or other brief appointments. They would not need to prepare lunch, since food was to be served at the sessions.

The program was designed so that women came into it as they became pregnant. The first session had four mothers, but over the course of the 8 months the enrollment waxed and waned as the babies were born and other women became pregnant. The attendance ranged from 4 to 13 at any one session. All sessions were audiotaped and the tapes were made available to old and new participants. Written summaries of each meeting were passed out at the subsequent session.

The participants were first oriented to the program's policies and procedures. Each one was given a folder containing a welcome letter from the PES director and the writer (see Appendix J), literature and pamphlets that promoted health habits during pregnancy (see Appendix L), and a list of community resources in both English and Spanish.

Each attendee was informed that an anonymous sponsor had donated a cash gift of $20.00 and a sweater set for the new baby, contingent upon her attending at least one session a month unless she had medical reasons for not attending. The gifts would be given after the birth of the baby. There was also a door prize at each session and a small personal or baby gift for all those present. The writer knew that free food and gifts served as effective incentives to ensure regular attendance and group interaction, and to prevent attrition.

Upon arrival, each participant was weighed and had her blood pressure taken (see Appendix F). This activity always encouraged dialogue between the medical assistants and the participants. The women then picked up their food and sat down to eat it. The tables and chairs were arranged in a circle to promote maximum group participation and a conducive atmosphere. Since the participants had a lot in common, conversing with one another seemed natural.

An early assessment of dietary intake provided the opportunity to teach about foods recommended for pregnancy. Therefore, at the first session, the writer administered a 15-minute pre-nutrition assessment (see Appendix B); it reflected the women's use (or lack of use) of the required nutrients during pregnancy, and it presented or introduced other ideas for food that they could incorporate into their daily diet. Additional spaces were provided for them to record their own cultural dietary variations (see Appendix B).

The first two PES session were devoted to nutrition (see Appendix N, Recap of PES Sessions). The WIC and M&I staff used the responses from the pre-nutrition assessment as the basis for discussing optimum maternal diet during pregnancy, and showed a film about nutrition as related to the fetus in utero. They also talked about community resources for pregnant women. The women were encouraged to be active with these programs.

The third session dealt with the anatomical and physiological changes of pregnancy, starting with the early stages until after delivery. A renowned obstetrician/gynecologist with long experience with disadvantaged pregnant women, teenagers, and unmarried women discussed these fundamentals. He seated himself among the participants and became part of the group--in dress, manner, approach, and behavior--instead of setting himself above or apart from them. He presented information on a basic level, drew pictures and graphs, and answered questions that related to the male and female reproductive systems. He explained many common medical terms used by the professionals during pregnant women's visits to the clinics but not always understood by them (see Appendix K).

The fourth session had been scheduled to be unstructured and informal; because of a speaker's cancellation, this was true for the fifth session as well. Since there had been speakers from the beginning, this was the first time the writer and staff had the opportunity to get to know the group. The enrollment had increased, but by now the participants knew each other well and were addressing each other by first names. They used the opportunity to voice concerns and needs, to share past experiences, and to offer group support. In one of these sessions, the writer and staff focused on the impact of substance abuse on the fetus, in a group discussion.

The sixth session involved a 2 1/2 hour tour of the labor and delivery units of one of the largest health facilities in the city. The group also visited the Neonatal Intensive Care Unit, which most had never seen before. At the end of the tour, the hospital nurse reinforced the message of the program, that many of the babies' problems could have been prevented by prenatal health care of the mother.

The question and answer period had to be curtailed because of time. But it spilled over into the next session, when the same nurse came to the seventh session to continue the dialogue. The information the group had gained was reviewed and shared with those who had been absent from the tour. There were new questions, since the group had had time to think about the babies in the intensive care unit.

This session ended with a clinical psychologist speaking about the impact of newborns on the family. He endeavored to prepare the parents psychologically for what was to come. His theme was "stress and joy," and he provided strategies for integrating the needs of the new infant with those of other family members.

Substance abuse was steadily growing worse on the city streets, warranting a discussion about the effect of drugs on pregnant women and the fetus. In the eighth session, a speaker from the Alcohol and Drug Center spoke to the group, showed a film, and distributed posters, literature, and other handouts. At the end, some of the participants stood in line to discuss the issues further. Following the drug session, an attorney focused on the legal aspects of parenthood: the rights of a child, the fact that failure of parental responsibility can result in the child's being taken from them, one's obligation to report child abuse, and the cycle of child abuse and malnutrition.

The next session arose from the parents' own realization that they did not know enough about child growth and development, and their demand, loud and clear, for assistance: "I don't understand the developmental stages or what to expect from toddlers and young threes." This was echoed by the parents serving as baby-sitters. Therefore, an early childhood educator was called in to discuss growth and developmental stages. She stressed that infants are never too young to listen and start learning, and that babies are supposed to be nurtured and talked to.

Session 11 was purely spontaneous. No meeting had been scheduled on the regular day because of a legal holiday. Nevertheless, the center staff reported that a number of parents arrived at the center anyway, anticipating a session even though they had received no notice of it.

Two more medical sessions were important. A husband-and-wife dental team, who had seen many of the children in the writer's agency, conducted an oral examination of each participant. They discussed the basics of oral hygiene, with emphasis on teething in young children and caring for the infant's first teeth. The next scheduled speaker was a pediatrician who spoke about immunizations, anemia, asthma, well-baby appointments, etc. Information presented and handouts indicated that comprehensive prenatal care was available at different medical facilities, and strategies were suggested for approaching the health and social systems, such as making medical appointments early in the day, when the personnel are fresh and relatively unpressured, and before the clinics are flooded with emergency "walk-ins" who preempt priority over those with appointments. The group questioned her at some length about "hyped up"--that is, hyperactive children.

The final session of the practicum was a party and a round-up. Some of the former speakers returned, joining the pediatric nurse and dental consultant who had been scheduled to speak. A number of the mothers who had had their babies attended, and brought the infants as well as the significant others who had been their support during the practicum.

During the practicum, a great deal of support was given by the writer and staff, much of it subtle and integrated into other activities. But it also included individual counseling when necessary, to re-confirm or re-explain how to go about getting the support needed.

There was other and extensive one-on-one interaction. The writer called each mother for each session, sometimes more than once, to remind her of the session and the van pickup time. She also made home visits to each mother after the baby was born, bringing the money and gift, and she took a picture of the mother and infant.

In addition, every effort was made to ensure that the basic needs were met for every participant. In some cases, this required purchasing milk for the infant and food for other family members; the writer and staff had to find adequate housing for three of the mothers; three others lacked clothing for bringing the baby home from the hospital; and shoes and baby clothes had to be supplied for one mother as an emergency measure. The writer had expected to serve a nutritious snack at each session, but this proved inadequate; travel to the sessions interfered with the normal lunchtime for the women and their children.

Therefore, more substantial food had to be served, and required additional time for preparation. Provision had to be made for those needing special foods.

Originally, the women were given bus tickets for transportation to the sessions. But it was cumbersome for women advanced in pregnancy to get to the bus stop and make bus changes with 2 or 3 children in cold or icy weather. Therefore, the agency van was commandeered for those who had no car available. Bus tickets were still distributed for medical or related appointments.

Great volumes of educational material were presented, demonstrated, and practiced during the 8-month practicum. By the conclusion, relationships had been established, questions had been asked and answered, and information had been shared in a way that couldn't possibly have happened in a clinical setting.

CHAPTER V

RESULTS, CONCLUSION, AND RECOMMENDATIONS

Results

The post-nutrition assessments and the evaluations cover results for 21 of the 25 participants. Two other participants returned their forms too late for inclusion in the practicum results. Two women were lost through attrition, for personal reasons, but their children remained enrolled in the preschool program, and the center staff continued to monitor their regular prenatal clinic visits and the progress of their pregnancies. One of these women gave birth to a 6 lb, 2 oz baby boy, and the other has not yet delivered.

Objective one was that all participants would learn more about prenatal care. The rationale for using the attendance sheets (see Appendix A) as the measuring instrument was that if the women came, they would learn. The participants faithfully signed the sheets or reported an "excused" absence. However, all the participants did attend at least one session per month, as the objective stated. Moreover, the majority of the women unexpectedly continued to attend the sessions even after their babies were born. But based on all the written evaluations received (see objective 7), the participants were enthusiastic about what they had learned. Therefore, the objective was met.

The pre- and post-assessments (see Appendix B) for objective 2 served as excellent teaching tools throughout the program, and were useful in giving information about the participants' likes and dislikes. But for all practical purposes, this measuring instrument contained a number of flaws that inhibited some statistical data. First of all, the pre- and post-tests biased the results because the first lines read: "Nutrition is important for you and your baby. Please check how often you eat or drink any of the following daily." These are suggestive, leading statements, and create a positive bias. Second, because of the way it was structured, the instrument did not measure the objective for which it was designed, the recognition of wholesome as opposed to junk foods. It emphasized what the participants ate instead of what they knew (see Tables 4-7).

Table 4.

Nutrition Assessment - Milk Group

Pre (N=25) Post (N=21)

	MILK (servings daily)				Cheese/Slices					MILK PRODUCTS-Yogurt, Milk Shakes, Ice Cream (Cups)				
										Daily				Wkly.
	1	2	4	>4	0	1	2	3	>3	0	1	2	3-4	3-4
Pre	1	16	6	2	4	2	13	4	2	2	3	5		15
Post		5	16			2	11	5	3	4	8	2		7

Kinds of Milk	Whole	2%	1%	Skim
Pre	12	12	1	
Post	9	12	1	

Table 5.

Nutrition Assessment - Meat/Beans Group

Pre (N=25) Post (N=21)

	MEAT* (servings daily)					DRIED BEANS				
								Weekly		
	None	1	1-2	2-3	>3	None	Daily	1-2	2-3	4
Pre		1		12	12	1	7	15	2	
Post			4	15	2	1		16	4	

* Includes fish, poultry, eggs, and cottage cheese

Table 6.

Nutrition Assessment - Bread/Grain Group

Pre (N=25) Post (N=21)

	BREAD* (Servings Daily)					**PASTA/RICE/NOODLES** (Servings Daily - Cups)	
	0	1	1-2	3-4	More	3-4 Daily	3-4 Weekly
Pre		1	7	12	5	7	18
Post		1	5	12	3	14	7

* Includes rolls, muffins, pancakes, and waffles.

Table 7.

Nutrition Assessment - Vegetable/Fruit Group

Pre (N=25) Post (N=21)

	VEGETABLES (Servings - Cups)					**JUICE/FRESH FRUIT*** (Daily Servings)	
	Daily				Weekly		
	0	1/2	1	>1	2-3	0	Daily
Pre		6	12	7		10	15
Post		4	8	1	8		21

* Choices were orange juice, apple, orange, and banana.

The assessments also need to be clarified and made more specific, to explain, for example, that one glass of milk equals one serving in the milk group, and the number of slices of cheese constituting an ounce. The participants might also not have realized that, for calcium intake, "milk products" were valid substitutes for milk--that is, that servings within the milk group were equivalent. Some of the categories were too narrow: nuts, sunflower seeds, and especially peanut butter could have been added to the meat/beans group; "grains" could have indicated cereal and crackers as well; and "pasta" should have comprised spaghetti and macaroni. The vegetable group should not have been limited to "your favorite," since that did not allow for other vegetables to be mentioned even though the women might have been consuming others, and both "raw" and "cooked" should have been indicated. A wider selection of fruit should have been allowed.

Although not among the basic four food groups, sweets/snacks were also reported (see Table 8). The post-assessment showed a substantial decrease in the consumption of junk food. On both pre- and post assessments, all participants denied consumption of beer or other alcoholic beverages.

Table 8.

Nutrition Assessment - Sweets/Snacks Group

Pre (N=25) Post (N=21)

SWEETS AND SNACKS (each day)

	None	Candy	Potato Chips	Pop	Beer
Pre	7	8	10	18	0
Post	7	3	2	9	0

It should be cautioned that in self-reporting, the validity of the data depends heavily on the participants' ability and willingness to report true information.

Objective 3 stated that all participants would follow physicians' orders. Based on the conversations in the sessions, all women complied, keeping their medical appointments as scheduled. There were no reported or identified major complications during pregnancy or at the time of delivery for 19 of the expectant women (see Appendices E and G), and therefore written records of kept and unkept appointments (see Appendix D) were maintained consistently only for the one participant who was at risk. This one exception was a diabetic woman who kept all her clinic appointments but did not adhere to her dietary regimen, although she knew she was at high risk. A written record was maintained of her condition by the writer. The writer and team nurse at the clinic shared notes and kept a close watch on this woman until she delivered (see Appendix C).

The participants' weights (objective 4) and blood pressures (objective 5) were measured at each session as tools for easily identifying severe medical problems (see Appendix F). The diabetic woman mentioned above was the only participant who gained more than 35 lbs. or had hypertension/blood pressure above 140/90 mm Hg (range, 136/70 to 150/90). The other readings ranged from 100/60 to 140/80 and did not warrant medical referral to the attending physician.

Objective 6 required that 18 of the 25 babies would be born full-term and weigh at least 5.5 lbs. This objective was met successfully; as of the end of the 8-month practicum, 19/20 babies met these criteria (see Appendix G). In only one instance, the baby was premature because of a rare medical condition that surfaced suddenly and was beyond the doctor's control, resulting in a preterm baby weighing 1.19 lbs; it was reported to be "healthy" and gaining weight rapidly. This mother enrolled in the PES program late in her second trimester. Nevertheless, in a newspaper article (see Appendix O), she credited the program with saving the lives of herself and her baby by emphasizing the importance of doctors' visits during pregnancy.

Table 9.

Birth Weight of Babies Born to Women in the PES Program

Birth Weights of Babies Born			
Infant	Weight (lbs)	Infant	Weight (lbs)
1	6.19	11	7.63
2	8.31	12	6.88
3	9.88	13	8.00
4	7.13	14	7.38
5	5.56	15	7.13
6	6.75	16	5.31
7	7.25	17	1.19
8	8.25	18	7.13
9	7.72	19	6.82
10	7.44	20	6.31

Summary: Twenty babies; mean weight = 6.91 pounds; standard deviation weight = 1.68 pounds. Value for *t* = 3.76; *p* value = .0013.

There are two possible ways to interpret these results. The null hypothesis states that the program had no beneficial effect on birth weights. The alternative hypothesis says instead that the program increased the mean birth weight for the babies born. It can be concluded from a t-test analysis that the birth weight of babies born to mothers who attended the Prenatal Education and Support program was significantly higher than the normal minimum of 5.5 lbs. The analysis includes the weights of the baby weighing 1.19 lbs as well as the 9.88-lb infant born to the diabetic mother. Although statistically there could be arguments for not including these values in the analysis, it was decided to keep both babies in the study.

All 21 of those who returned the evaluations had a positive attitude to the program and to their pregnancy, thus fulfilling objective 7. This was measured by a self-reporting instrument in two parts (see Appendix H). The first five questions asked for yes or no answers to questions about the interest and educational value of the PES program. All participants without exception responded favorably to all the questions, indicating a positive attitude. The second five questions asked for a more active response.

Question 1.

Do you believe that you have increased your knowledge about parental care and delivery during the sessions you attended? Explain why or why not.

Three of the 21 stated that their knowledge of nutrition was increased. Four claimed that they had learned a great deal from the support of the group and the exchange of information. Fourteen indicated that the topics presented in the sessions provided them with the most valuable information.

Question 2.

Will some of the information we recently learned be useful to you during your future daily living? Explain your answer.

Four participants responded with only a "yes" answer. Seventeen supplied the explanation requested. Appendix H gives 13 of the statements received (four of the responses repeated the same points).

Question 3.

What did you like most about the Prenatal Education and Support program?

The writer expected a single answer to this question, but 13 participants gave multiple responses. They overwhelmingly cited the support of the staff and the group (13 mentions) for its "attention and concern," and "respect and attention received by all"; "it makes you feel like you are part of a large family." Six approved of the educational information and the speakers; three others appreciated the help in maintaining their weight and blood pressure and in keeping their medical appointments. The nutritious food (six mentions) and gifts (two) were cited, and also the opportunity for the children to attend (one). One response expressed particular gratitude for information on how to prepare the other children for the new baby.

Question 4.

What did you like the least about the prenatal sessions? Explain your answer.

Twenty of 21 participant response to the question said, "Nothing." One lone participant said that walking to the bus stop to take public transportation was cumbersome, especially with other small children and especially in bad weather.

Question 5.

What topics would you suggest if there is another prenatal education and support program? Please list topics.

Some of the topics requested for future programs were:

Problems and complications during pregnancy
Delivery processes
Vaginal infection
Nutrition education
Drug education
Early child growth and development
Care of the new infant
Bathing the new infant
Dealing with other children and the new baby

Breast feeding

Preparation of the baby's formula

Immunizations/medical screenings

This self-reporting instrument asking a series of questions was valuable in obtaining a needs assessment for the targeted population.

It was concluded that many pregnant women need and want more information about all the aspects of the experience they are going through, and are open to receiving it if it is presented in an emotional and psychological context of support from the staff, the professionals, and the group--that is, from everyone involved.

At the end of the 8-month practicum five babies have yet to be born. Including those five mothers who are still pregnant, fifteen of the original participants remain active in the PES program.

Conclusions

Twenty of 25 babies were born during the 8 months of the practicum implementation. Nineteen of them were full-term and weighed well above 5.5 lbs., the objective's minimum and the boundary for "low birth weight" according to accepted definitions. Only one baby was born early and with weight below that level: it was delivered by cesarean section and weighed 1 lb. 3 oz. The mother was into her second trimester when she began the program, and came only 4 times before giving birth; she had no telephone.

Since the evaluation tools were weak, the results for several objectives could not be measured accurately. The responses on the evaluation and behavior of the participants remain a better guide to the program's accomplishments. They provide ample grounds for believing that the objectives were nevertheless met successfully.

The pre- and post-nutrition assessments were ambiguous in ways that had not been foreseen, and therefore did not reveal conclusive evidence of the participants' eating habits before and at the end of the practicum. If used again, their language would need to be clarified and the biases eliminated. Also, ideally, a control group would more precisely indicate how much the sessions increased the women's knowledge of nutrition, although this would require more time and personnel.

But the assessments were effective as teaching instruments. Based on the absence of possibly diet-related complications (e.g., edema, constipation), the participants paid attention to their food habits. The evaluation questionnaire, where their increased knowledge about nutrition came up often, revealed clearly that the participants themselves felt they had acquired a new knowledge about nutrition. One woman stated in a television interview that she had "learned a lot" about diet during pregnancy, and that she had incorporated many of the principles she had learned into her own diet and the daily diet of her family.

The women were receptive to the principles and practices of the program. Their commitment was such that the writer did not think it necessary to monitor the group's clinical appointments. Parents would call assiduously if they had a medical or WIC appointment. Afterward, what had transpired at that appointment, including the date of the next appointment, became a major topic of discussion. Moreover, the group was helpful in aiding and ensuring that medical appointments were kept for others. Two women had deliberately missed their initial appointments; it was the support of the group that helped them to make and keep their subsequent appointments.

The participants were committed to the point where they arrived even though no session had been scheduled. The writer had originally planned to make two home visits, one just after the baby's birth and a follow-up about a month later. The second visit proved unnecessary, since all (except two who were followed by center staff) unexpectedly continued to attend the sessions even though attendance was supposed to have concluded with birth.

Many opportunities for personal exchange had been built into the PES program, and the communication between the participants, the writer, and the staff was excellent. A real sense of sharing and caring developed. They looked after each other. Several called to tell the writer when others were in need, and one donated extra infant clothing.

All the experiences of pregnancy--doctor's instructions, weight gain--were discussed, as the participants empathized with each other and compared notes. Often, the exchange involved the disclosure of confidential issues, both positive and negative. The trust exhibited by the women was genuine and loyal.

As foreseen, staffing was a major problem for the practicum. The workload and demands were overwhelming, and there was inadequate staff to assist with the preparation of food on site, collect information, and maintain records. A large part of this was done at home by the writer after normal working hours. Unanticipated help came from a graduate student in Counseling and Human Services, who was an intern for 3 months. For this brief period, her presence was helpful. But the 8-month practicum required continuous bustle to purchase supplies or items needed by the participants; to do an enormous volume of telephoning; to pick up and organize pledged donated items; to prepare food and gifts; to handle thank-you notes and other correspondence. The writer was in frequent telephone communication with those participants who had telephones, but had to rely on already-overworked center staff for outreach to those without telephones.

Many of the problems that were reported and discussed in the literature were also noted in the writer's program. Three of the pregnant women were very transient; one moved three times within the 8-month period and two moved three times. This included living with relatives and friends in cramped quarters. Their housing situation was often reflected in their attitudes toward the social and economic systems.

Attempts were made to help the women cope with the basic necessities of life, but there were a number of depressing and frustrating situations. The writer tried to obtain any item needed for taking the babies home from the hospital, and even afterward, but this was not always possible. One woman expressed the need for a crib, a high-chair, and a car seat. Another, a single pregnant mother who was struggling with six children, the youngest under age 7, had inadequate food, housing, and shelter, which the writer could not possibly alleviate.

The initial speaker agenda turned out to be tentative and had to be modified because of the unavailability of speakers or their cancellations. This proved to strengthen the program. First, the revised calendar allowed for a more logical sequence of speakers. Then, the gaps provided time and space for the development of invaluable group emotional support and for feedback from the participants.

As their confidence grew, they began to express their own needs themselves. A number of practical modifications in the program as originally conceived arose out of their own requests and led to modification of strategies for strategies for future programs. From the beginning, the participants arrived at the sessions with their "significant others"--family, friends, spouses--for support. This was unanticipated, but it was quickly encouraged by the writer. The speaker on early childhood growth and developmental stages came because the women voiced their need for help in this area.

The program's outcome is directly related to its design for this particular setting and population. An initial feeling of apprehension or mistrust of such a program would be natural for this population, but here the ice was already broken. By definition, the women had children in the preschool and were physically present at the center twice a day to deliver and pick up their children. They were thus well acquainted with the staff. Then, too, the center staff could work closely with the parents and take the initiative in drawing them in; in the course of their ordinary preschool outreach activities the center staff operated as outreach for the PES program as well. This was important because many of the participants had no telephone, and the mailed reminders were frequently returned by the post office. The fact that the center staff was already in the area allowed outreach to function.

The program received strikingly strong support from the community. The writer had anticipated donations of $5,000 for the 1-year funding period, but $5,500 had been received by the end of the 8-month practicum. Most of the larger businesses in the area had already committed their donations for the year, but individuals, small businesses, churches, and sororities were overwhelmingly generous with both money and commodities.

Recommendations

1. Adequate staff should be in place. Trained personnel need to be exceptionally accessible to the women.
2. Each step in the program should be built upon the previous step in a sequential fashion that can be integrated into daily activities.
3. The atmosphere should be conducive to a feeling of excitement and pride about having a healthy baby.
4. The input from and assistance of an advisory committee would be helpful. This group would consist of former participants who would serve as role models and help plan and implement the program.
5. The parents who work as baby-sitters should be under the supervision of an educator, social worker, or psychologist. These professionals would provide needed training in effective parenting skills, which could then be disseminated among other parents in the preschool setting.
6. Films related to pregnancy and child care are available (see Appendix P) and should be used as segments of the program.

7. Professionals should make every effort to communicate to elected officials the situation of the disadvantaged population and request resources for change.

Dissemination

The results of this practicum have been shared with seven other preschool directors and health coordinators. Next, the practicum was reported in two newspapers in the writer's city. During its midpoint, it was aired on two local television stations for 2 days (see Appendix O). The writer has discussed the PES program and its objectives with a city councilwoman for that area and with Congressman Louis Stokes, who has pledged to do whatever he could as a congressional leader to promote a program of this nature for the disadvantaged population.

The PES program has also been disseminated to the preschool agency's officials at the state and regional levels. The Maternal and Infant Health Program staff is collaborating with the writer in the attempt to integrate a substance abuse curriculum into the PES program for babies born to women who use crack and other drugs. The writer's contact person at the George Gund Foundation is citing the program to the foundation's Board of Trustees as having received a small grant resulting in large gains, and having more than matched that grant with donations in kind. The PES program is being re-funded for a second year's implementation.

CALENDAR

The calendar consisted of the following agenda.

PES orientation for administrative and center staff.

Session 1: Presentation #1 by RDA nutritionist.

Session 2: Presentation #2 by RDA nutritionist.

Session 3: Obstetrician/gynecologist

Session 4: Discussion and sharing of concerns among participants and support members; counseling.

Session 5: Continuation of discussion and sharing by group and support members; counseling.

Session 6: Tour of Neonatal Intensive Unit at the Metropolitan Medical Center.

Session 7:

Part 1: Continuation of the discussion of issues from the visit to the Neonatal Intensive Unit at the Metropolitan Center.

Part 2: Clinical psychologist
The stress and joy that comes with a newborn.

Session 8: Drug Counselor - The effect of drugs and alcohol on the fetus.

Session 9: Practicing Attorney
Legal responsibilities and consequences.

Session 10: Educator in Early Childhood (Teacher)

Session 11: The PES group met (unscheduled meeting) without notice.

Session 12: Dentists

Session 13: Pediatrician
The medical care of infants.

Session 14: Sharing, counseling, program evaluation, input for future planning.

Session 15: Party and round up; pediatric nurse and dental consultant; return of former speakers and participants.

The content of each session was summarized and printouts given to participants at following session (see Appendix N). Summaries were translated into the informal Spanish spoken by the target population.

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APPENDIX A

P.E.S.

ATTENDANCE SHEET

PARENTS SIGN IN SHEET

Date ____________________

	CENTER

STAFF

APPENDIX B

PRE- AND POST-NUTRITION ASSESSMENT IN ENGLISH AND SPANISH

The Spanish translations are in the colloquial language of the population served.

Pre- and Post-Nutrition Assessment

Nutrition is important for you and your baby. Please check how often you eat or drink any of the following:

Each Day

Milk Group

Kind: Whole 2% 1% Skim

None 1 glass 2 glasses 4 glasses More

Cheese: None 1 slice 2 slices 3 slices or More

Yogurt, Milk Shake, and Ice Cream

None 1 cup 2 cups 3-4 cups 4-5 cups [per week]

Meat Group

Meat, fish, poultry, eggs, cottage cheese

Kind:____________________________

None 1 serving 1-2 servings 2-3 servings or More

Dried Beans (navy, pinto, kidney, peas)

None Daily 1-2 times weekly 2-3 times weekly

4 times weekly or More

Breads rolls, muffins, pancakes, waffles

None 1 serving 1-2 servings 3-4 servings or More

Pasta, rice, noodles (amount each day)

3-4 cups or 3-4 times per week

Vegetable Group

Your favorites__________________________________

Amount each day: None 1/2 cup 1 cup

more than 1 cup - 2-3 times a week

Pre- and Post-Nutrition Assessment
(continued)

Fruit/Fruit juices/Vitamin C

Kind: ______________________________

None orange juice fresh apple orange banana

Sweets and Snacks each day:

None Candy Potato Chips Pop Beer

Pre- and Post-Nutrition Assessment

Nutricion es importante para tu y a tu bebe. Por favor marca cuantos veces se comen o beben cualquiera de los siquientes:

Leche

Tipo: Leche sin desnatar 2% 1% Leche desnatada

Nada 1 vaso 2 vasos 4 vasos Mas

Queso: Nada 1 tajada 2 tajadas 3 tajadas Mas

Yogur, batido de leche, mantecado:

Nada 1 taza 2 tazas 3-4 tazas 4-5 tazas [semanal]

Carne

Carne, Pescado, Pollo, Huevos, requeson curjada

Tipo ______________________________

Nada 1 porcion 1-2 porciones 2-3 porciones Mas

Habichuelas Seca

Nada Diara 1-2 semanalmente 2-3 semanalmente

4 semanalmente Mas

Pan torta, molleto, panqueque, panqueque al estilo de barguillo

Nada 1 porcion 1-2 porciones 2-3 porciones

3-4 porciones Mas

pasta, arroz, fideos (cantidadess cada dia)

3-4 tazas or 3-4 tazas semanalmente

Vegetales

Sus Favoritos ______________________________

Cantidades cada dia: Nada 1/2 taza 1 taza

mas de 1 taza - 2-3 semanalmente

APPENDIX C

Log for Communication

Among Doctors, Nurses, and Writer

Date	Name of Dr./Nurse Spoken With	Physician's orders
________	____________________	________________
		Verbal__________
		Written__________

Name of Patient____________________

Projected date of Delivery__________

Age__________

Patient's problems or clarification of prescribed orders.

Comments:

APPENDIX D

LOG FOR CLINICAL APPOINTMENT DATES

KEPT AND UNKEPT

Clinical Appointment Dates

Kept and Unkept

1. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

2. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

3. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

4. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

5. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

6. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

7. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

8. Date of Appointment Appointment kept Yes/No

_____________________ If no, why?____________

Carfare requested/needed_____

APPENDIX E

Log for Complications of Pregnancy, Labor, and Delivery

Signs and symptoms most commonly experienced during pregnancy.

Date__________

Signs

edema in:
face________
feet________
ankles________
legs________

Weight:
excessive weight loss________lbs.
excessive weight gain________lbs.
No weight gain__________
Induced high blood pressure________
Systolic/Diastolic readings__________
Depression______________________

Date__________

Symptoms

Headache______________
length of time
(medication taken if any)
Abdominal discomfort________
Vaginal bleeding__________
Vaginal itching or burning
during urination________
Any form of skin rash________
Physical Examination________

Other medical conditions related to chronic illness (i.e. diabetes, cardiac condition, etc.).______________________

____

____

____

____

APPENDIX F

Log for Weight/Blood Pressure

Name____________________

Address____________________

Age____________________

Date____________________

BP____________________

Wt.____________________

Date____________________

BP____________________

Wt.____________________

Date____________________

BP____________________

Wt.____________________

Comments

APPENDIX G

LOG FOR BIRTH OF INFANTS

Birth of Infants

Mother's last name	Date of birth	Full-term yes/no	Weight	Complications
1. Baby__________				
2. Baby__________				
3. Baby__________				
4. Baby__________				

APPENDIX H

EVALUATION

Circle your response to the following questions.

Yes	No	1. Was the program a worthwhile event?
Yes	No	2. Was the program well organized?
Yes	No	3. Were the topics interesting to you?
Yes	No	4. Did you learn from the presentations?
Yes	No	5. Would you recommend this program for other expectant parents?

Answer the following Questions as fully as you can.

1. Do you believe that you have increased your knowledge about parental care and delivery during the sessions you attended? Explain why or why not.

____

____

2. Will some of the information we recently learned be useful to you during your future daily living? Explain your answer.

____

____

3. What did you like most about the Prenatal Education & Support Program? Explain your answer.

____

____

4. What did you like the least about the prenatal sessions? Explain your answer.

____

____

5. What topics would you suggest if there is another prenatal education and support program? Please list topics.

____

____

Statements made by 13 of the 17 participants are cited:

1. "I learned that a pregnant woman should eat the right foods."
2. "How to use programs like WIC and the M & I."
3. "If I have a problem with my newborn that is not serious, I can get answers and support from the group."
4. "I can be more aware of eating habits and changes in my diet and moderate exercise."
5. "I can make better choices in planning meals for my family."
6. "Getting help you feel you need to get out even if its for air."
7. "If I didn't have the class, I wouldn't know what to do."
8. "I learn how to prepare my other children for the new baby."
9. "I read those booklets daily. I have 3 children and they really help a lot."
10. "There was a lot that I didn't know that I learned in the program. I have 5 babies."
11. "All of the information that I learned will be helpful because I learned that taking care of my body all the time is important."
12. "I was able to see how taking care of my body is important all the time."
13. "The part about eating right not only during pregnancy, but all the time."

APPENDIX I

LOG OF UNANTICIPATED EVENTS

APPENDIX J

WELCOME LETTER TO PARTICIPANTS IN ENGLISH AND SPANISH

September 25, 1989

Welcome to P.E.S.:

The ______________________________ wishes to welcome you to its subsidiary group, P.E.S. (Prenatal Education and Support Group).

P.E.S. is here to help you enjoy your pregnancy. We will provide presentations on nutrition, counseling services, information on community resources, drug education and many other topics useful to you during your pregnancy. In addition, P.E.S. will provide nutritional snacks at meetings; bus fare for transportation needs and baby-sitting services for those of you who need it.

Again, let me say, welcome to P.E.S.

Yours truly,

Sarah Mack,
Program Coordinator

Septiembre 25, 1989

Bienvenido a P.E.S.

El ________________________________desea darte la Bienvenida al grupo De P.E.S. (Prenatal Education and Support Group).

P.E.S. esta aqui para ayudarte a disfrutar de tu embarazo. Te daremos presentaciones sobre nutricion, servicios de consejos, informacion sobre recursos en la communidad - educacion sobre drogas y otras topicos que te ayudaran durante tu embarazo. Adicionalmente, P.E.S. dara meriendas nutritivas en las reuniones - dinero para transportacion y cuido de ninos para los que lo necesiten.

Otra vez, dejame decirte - Bienvenida a P.E.S.

Attentamente,

Sarah Mack,
Coordinadora del Programa.

APPENDIX K

DEFINITION OF MEDICAL TERMS
IN ENGLISH AND SPANISH

COMMON TERMS OFTEN USED BY MEDICAL STAFF DURING PREGNANCY

Explained in simple terms by the Obstetrician/Gynecologist.

Family History:

During the expectant mother's first visit to the doctor, she is asked a number of questions about her history. This information is recorded on a number of forms. Family history is important because it tells the doctor about diseases and health problems of the patient and about her family's medical background. The mother's general history is more important than the father's.

Examples:

Diabetes mellitus
Sickle Cell or Sickle Cell trait
Hypertension (high blood pressure)

Tests: Blood and urine are common tests performed throughout pregnancy.

Blood Tests:

Hematocrit/Hemoglobin are done to test for anemia
Venereal Diseases - to test for syphilis and AIDS
Rubella-to check for titer level
Diabetes mellitus to check for hyperglycemia and to prescribe the proper diet and medication, if needed
Urinal infection

Urinalysis (Urine test) is required frequently

Bacteria infection
Blood in the urine
Glycosuria - an excessive amount of sugar in the urine

Albuminuria-the spillage of protein in the urine.

It usually happens in the third trimester and suggests the beginning of pre-eclampsia which requires immediately treatment to prevent the development of serious problems. The expectant woman needs to be aware of the following signs and symptoms:

1. edema in hands, face, and ankles; most noted in the morning.
2. Be aware of sudden weight gain
3. There is an increase in the blood pressure

These signs/symptoms should be reported to the physician at once.

Blood Pressure taken to detect hypertension, a condition common among blacks.

Weight taken to monitor excessive and rapid weight gain. Weight gain should range between 25-30 lbs.

Episiotomy an incision (or cut) of the perineum to prevent tearing of the maternal tissues and/or to avoid damage to the fetus' head.

Jaundice the bilirubin content in the infant's blood that often increases soon after birth.

Meconium first stool of the newborn; it is tarry.

Amniotic Sac a bag of fluid that contains the baby. It is called a water bag.

Placenta Barrier is described as thin walls between the baby and the mother. It is the placenta where nutrients are transferred to the baby and wastes taken from the baby into the mother's body. Some harmful toxins can cross the placenta barrier (Appendix L).

Abruptio Placentae is a result when the afterbirth starts to separate from the uterus before the baby is delivered.

Birth Defects

Birth defects that occur from chromosomes:
Sickle cell disease is common among Blacks.
It is a genetic defect where the red blood cells take on a sickle shape as apposed to a circular form.

Down's Syndrome (mongolism) A form of mental retardation. A condition related to maternal age over 35.

Amniocentesis A simple procedure where a sample is taken from the bag of water to detect any abnormalities.

Ultrasound is excellent for revealing:
- Location of the placenta
- Size of the water bag
- Most times, the sex of the child can be determined
- Helps to give an accurate date of the pregnancy and rule out multi-births
- Detects abnormalities such as hidden blood clots.

Terminos comunes usados frecuentemente por el staff medico durante el embarazo

Historia familiar: Durante la primera visita del embarazo el medico le hace una serie de preguntas a cerca de su historia familiar y personal de salud. Esto es importante porque le informa al medico acerca del pasado personal y familiar. La historia de la madre es mas importante la que del padre.

Ejemplo:
Diabetes mellitus
anemia falsiforme o portador
hypertension

Examenes
Examen de sangre:

Hematocrito/Hemoglobina: Para examinar si hay anemia.

Enfermedades venereas: examen de sifilis y SIDA

Rubeola: para examinar los niveles de titulos

Diabetes mellitus: para examinar lo hiperglicemia y poder prescribir una dieta y medicamento adecuados.

Examen de la dima (Urinalysis) es requerido frecuentemente.

Albuminuria (albumina en el orina)
Esto usualmente pasa en el tercer trimestre y indica el principio de pre-eclampsia y requiere inmediato tratamiento para prevenir el desarollo de problemas serios. La madre embarazada necesita estar atenta de los siguientes sintomas:

1. Hinchazon en las manos, cara, y tobillo, mas frecuente en la manana.
2. Estar atenta de un aumento de peso subito
3. Aumento en la presion de la sangre.

Estos sintomas/signos deben ser reportados al medico inmediatamente.

Saco Oriminotico: Es la bolsa de fluido que contiene al bebe y es llamada bolsa de agua.

Barrera Placentaria: Es descrita como una (delgada pequena) pared entre la madre y el bebe; es el lugar donde los nutrientes son conducidos al bebe y los residuos son conducidos del bebe al materno; algunas toxinas daninas pueden cruzar la barrera placentarim.

Abruptio Placentico: es la separacion de la placenta del utero antes que nazca el bebe

Defectos de Nacimientos: Que ocurren por cromosomas. Anemia Falsiforme: Comun entre los negros; defecto genetico donde el globulo rojo (es mas) en vez de ser circular toma la de una us.

Mongolismo (Sindrome Down): una forma de retardo mental y en relacion a madres mayores de 35 anos.

Amniocentesis: un procedimiento sencillo que parte del liquido es tomada de la falsa amniotica en el utero y evaluada para detectar anormalidades.

Ultra sonido: Es llevada a cabo para revelar la posicion de la placenta, tamano de la bolsa de agua.

El sexo del bebe se puede determinar con este examen.

Ayuda a dar una fecha o edad al la gestacion acertada y identifica gestacion multiple; tambien puede determinar anormalidades tales como coagulo de sangre oculto.

Episiotomia: Es una insicion o corte del perineum para prevenir el desgarramiento de los tejidos maternos y a la vez evita danos de la cabeza del feto.

Ictericia: El contenido de bilirubin en la sangre del bebe, muchas veces puede aumentar despues del nacimiento.

Meconium: Primera excreta del bebe; usualmente es oscuro (negro).

APPENDIX L

FLYERS AND HANDOUTS

IN ENGLISH AND SOME SPANISH

DATE______________________________________

TO____

FROM: SARAH MACK AND STAFF

SUBJECT: PRENATAL CLASS

WHEN:______________________________________

WHERE:_____________________________________

Pregnancy is a Miracle from on High - - - -

DR._________________________________

PRESENTING

"HUMAN ANATOMY AND PSYCHOLOGY AS RELATED TO PREGNANCY, CHILDBEARING AND BIRTH"

FECHA ______________________________

PARA ______________________________

DE: SARAH MACK AND STAFF

ACERCA DE: CLASE PRENATAL

CUANDO: ______________________________

DONDE: ______________________________

El embarazo es un milagro de Arriba! - - - -

DR. ______________________________

PRESENTADOR

"ANATOMIA HUMANA, Y PSYCHOLOGIA COMO RELATAN AL EMBARAZO, Y PARTO"

PREGNANT ?

join

P.E.S.

(Pre-natal Educational Support Grou

at

GET ACQUAINTED, REGISTRATION AND ORIENTATION

BEGIN TO ENJOY YOUR PREGNANCY!!!!!!

NUTRITIONAL SNACKS

BABY GIFTS

BABYSITTING SERVICES

COUNSELING

FREE TRANSPORTATION

CALL MRS. MACK at 791-7100

EMBARAZADA

unase a

P.E.S.

(Grupo de apoyo
Educacion Pre-Natal)

OBTEN INFORMACION, REGISTRACION Y YORIENTACION

EMPIEZA A DISFRUTAR TU EMBARAZO!!!!

REGALOS PARA EL BEBE

CUIDADO PARA NINOS

CONSEJERIA

TRANSPORTACION GRATIS

LLAME A MRS. MACK AL 791-7100

CHEMICAL ABUSE
LEGAL AND PHYSICAL ISSUES ON THE UNBORN CHILD

ABUSO DE CHEMICOS
LEGAL Y FISICO, DATOS SOBRE
EL NINO ANTES DE NACER.

OPEN
THE
DOOR
to
LEARNING
ABOUT

name ________________________

____

PES GROUP

VISIT
METRO HEALTH
MEDICAL CENTER

neo-natal clinic

prenatal clinic

premature Infant Care

healthy baby care

nutrition care

ABRE
LA
PUERTA
PARA
APRENDER
SOBRE

Nombre

Centro

PES GROUP

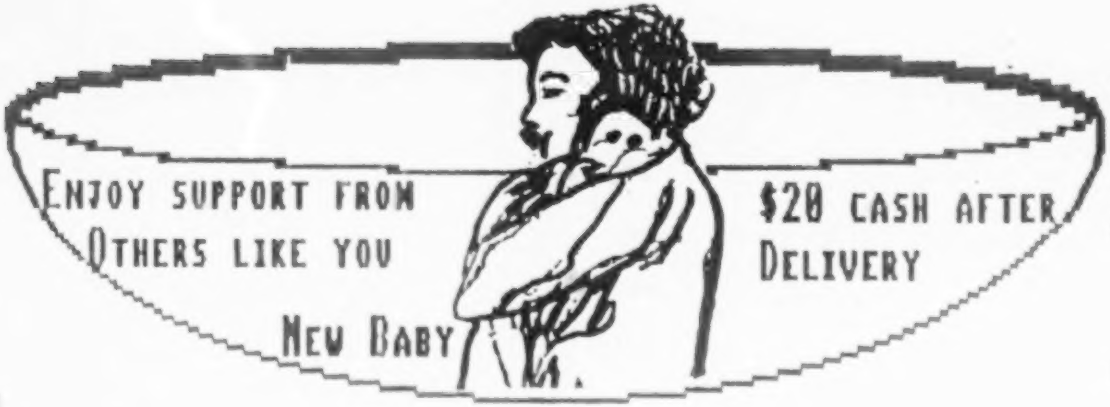
VISITA
METRO HEALTH
MEDICAL CENTER

neo-natal clinica
prenatal clinica
premature Infant care

cuido nino saladable
Cuido nutritivo

Attention: Are You Expectant?
All Mothers Who Are Pregnant in September, 1989
Join Headstart's New Prenatal Class
Enjoy & Receive a Bowl of Goodies

Bonus


Enjoy support from others like you
$20 cash after delivery
New Baby

Counselling
Sessions

Movies &
Speakers
- Doctors
- Nurses
- Psychologists
- Nutritionists
- Counselors
- Early-childhood educators
- Pediatricians

Car Fare - Public
Transportation
Agency's Van

Field Trips

Get Weighed
Blood Pressure
checked

Nutritional snacks and beverages

Babysitting services available at the sessions

Educational Classes

$25 Emergency
Food (if needed)

Call Mrs. Mack
791-7100

Todas Las Madres Que Esten Encintas As of Sept 1989
Registrese en Head Start's Nueva Clase Prenatal

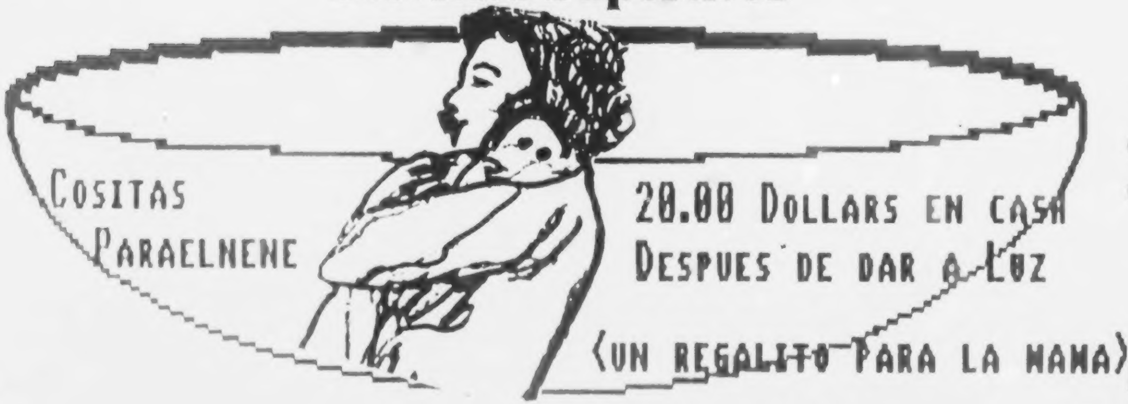
Gose de un Bowl de Servicios Suportivos

El parto
Trabajo de amor

Servicio de Concejos

Presenadores
Pelicuas

Groupo de socializiation



COSITAS PARAELNENE

20.00 DOLLARS EN CASA
DESPUES DE DAR A LUZ

(UN REGALITO PARA LA MAMA)

Transportation gratis
Publica/van de agencia

Jiras

Peso Y'lapresion Tomada

Cuido para ninos
Classes educativas

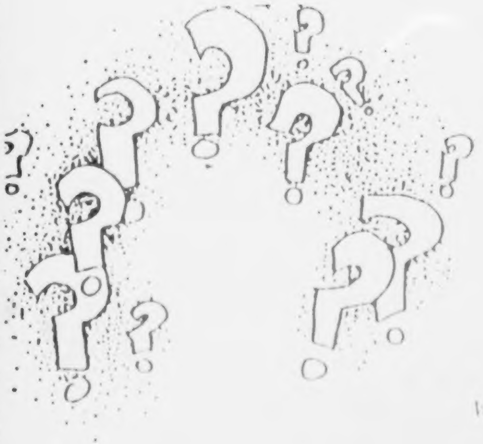
25.00 pesos certificodi de emergenci para comidi

Para mas information
Able con su consegero or llame al componente medical
791-7100

MOM

HOW TO HELP YOUR CHILD BECOME A SUCCESS IN

LIFE



LEARNING STARTS ↘

PES

GROUP

INFANCY

PARENTS !

"YOU CAN MAKE THE DIFFERENCES"

WE WILL SEE YOU---------- On

TIME

AT ___________________

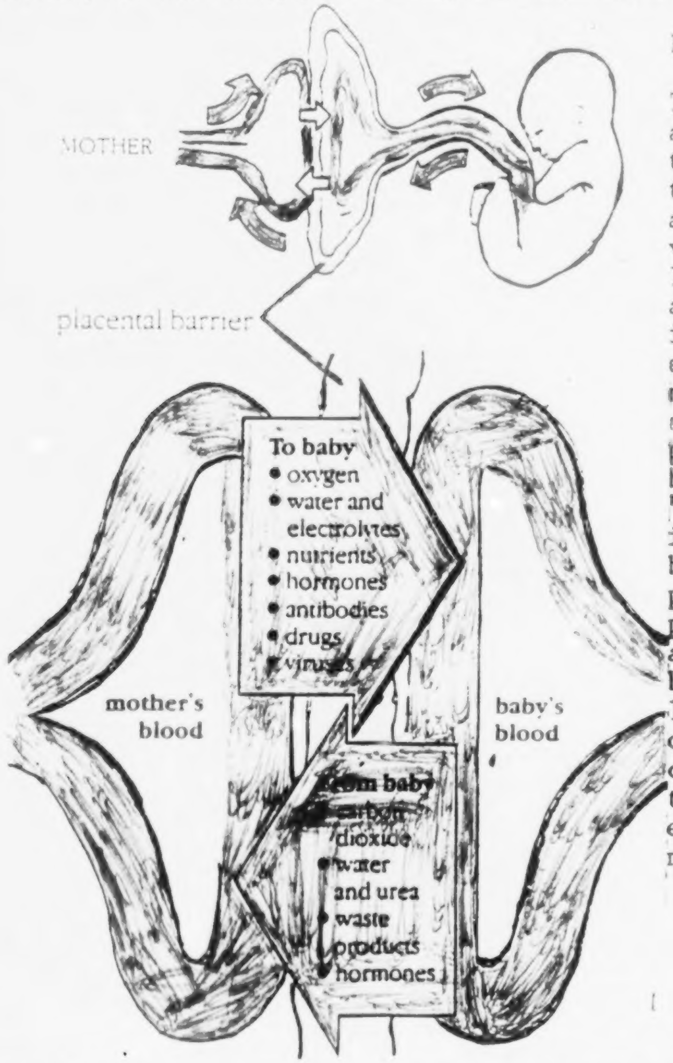
ESPECIALLY FOR:

LONELINESS
Social
SOP
ING

THE PLACENTAL BARRIER AND FETAL-MATERNAL CIRCULATION

Throughout pregnancy, the mother's circulatory system is separated from the fetus' by the placental barrier, a thin layer of cells shown here in highly diagrammatic form. This is where the vital exchange of nutrients and wastes occurs--and where substances that might be harmful to the fetus pass into the infant's body from the mother.

The placental barrier is the crucial bit of tissue standing between the growing infant, the mother, and the outside world. Although it is designed to form an effective barrier to some toxins, it cannot prevent the passage of harmful amounts of nicotine, alcohol, tranquilizers, or other drugs. Given the research evidence to date, a thoughtful woman in her childbearing years should not smoke, drink alcohol, or take drugs, including the over-the-counter variety.


MOTHER
placental barrier
To baby
• oxygen
• water and electrolytes
• nutrients
• hormones
• antibodies
• drugs
• viruses
mother's blood
baby's blood
From baby
• carbon dioxide
• water and urea
• waste products
• hormones

PLACENTAL CIRCULATION

The placenta is an amazing, complex organ that functions throughout fetal life in a variety of jobs, all vital to the infant's life. The placenta acts as a buffer between the infant and the external environment of the mother's body. It allows nourishment to pass from the mother's blood through the "placental barrier" and into the infant's bloodstream. The placenta also forms a protective barrier against some toxins and bacteria; it acts as lungs for the transport of oxygen and carbon dioxide, as a kidney for the infant, and as an endocrine gland for the mother.

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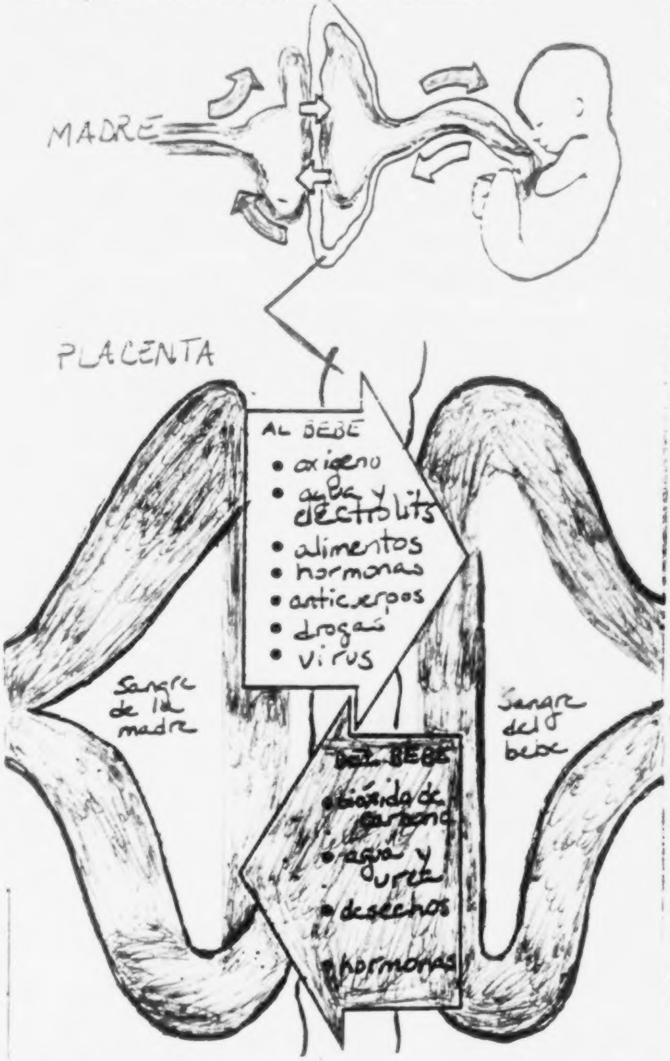
EMBARAZO: LA PLACENTA Y CIRCULACION DE MADRE Y FETO

Durante el embarazo, el sistema circulatorio de la madre es separado del feto por la placenta, una capa finita de celulas presentado aqui, como se puede ver en el diagrama.Aqui es donde hay el cambio vital de alimentos y al mismo son expulsados, y donde las sustancias dañinas pasan de la madre al feto.

La placenta es un tejido crucial entre el feto y la madre y el mundo exterior (afuera). Aunque fue diseñado para former una barrera efectiva de algunas toxinas, no puede impedir paso de cantidades peligrosas de la nicotina, alcohol, tranquilizantes, y otras drogas. Dados estos datos hasta hoy, la mujer debe pensar en sus años de maternidad, que no debe fumar, tomar alcohol o coger ninguna droga, incluyendo las drogas sin recetas.


MADRE
PLACENTA
AL BEBE
• oxigeno
• agua y electrolits
• alimentos
• hormonas
• anticuerpos
• drogas
• virus
Sangre de la madre
Sangre del bebe
DEL BEBE
• bioxido de carbono
• agua y urea
• desechos
• hormonas

CIRCULACION DE LA PLACENTA

La placenta es un organo maravilloso y compuesto "fabricado" que funciona durante la vida del feto en unas variedades de tareas, todo vital para la vida del infante.

La placenta actua como intercesora entre el infante y el ambiente exterior del cuerpo de la madre. Permite que los alimentos pasen de la sangre de la madre por la placenta a la corriente sanguinea del infante. Que la placenta tambien forma un barrera protectiva contra las toxinas y bacterias.

Actua como pulmones para la transportacion de oxigeno y bioxido de carbona, tambien como riñon para el infante y glandulas endocrina (nombre de la glandula) para la madre.

Spanish Translation;
Original text from:

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HARMFUL HEALTH EFFECTS OF TAKING DRUGS DURING PREGNANCY

DRUG AND REASON FOR USE	EFFECT ON FETUS/SPECIAL CONSIDERATIONS
Alcohol Social and psychological factors	Heavy drinking may cause heart defects and facial, arm, and leg malformations. Children born of alcoholic mothers are likely to be addicted at birth and to go through withdrawal.
Cigarette smoke Social and psychological factors	The offspring of women who smoke cigarettes are smaller and are subject to higher perinatal mortality and morbidity. Smoking is related to increased risk of fetal malformations and stunted physical and mental growth. Major birth defects, congenital heart diseases, and cleft lip and palate are more prevalent in children of smoking mothers. ***SPECIAL CONSIDERATIONS** Cigarette smoking is clearly harmful to your own health as well as to your unborn child's. The more you smoke, the greater the dangers and the higher the risks.
NON-PRESCRIPTION DRUGS:	
Antacids Upset stomach, heartburn	Possible higher rate of birth defects when mother uses drugs regularly. *** SPECIAL CONSIDERATIONS** Small occasional does for extreme discomfort should be safe.
Aspirin Minor aches and pains	Mental retardation, limb abnormalities, fetal death, bleeding in the newborn, and other developmental defects. ***SPECIAL CONSIDERATIONS** Aspirin is an ingredient in many different medications. Read the label. The effects are increased when taken together with benzoic acid, a common food preservative. Aspirin given within two weeks of delivery may cause serious bleeding in the newborn and mother.

Aspirin Substitutes Minor pain and discomfort	It is uncertain what effects acetaminophen (the ingredient in aspirin substitutes) may have on the fetus. Studies have not yet proved its safety.
Cold remedies and sinus medications Itchy eyes and runny nose due to colds **Sleeping medications** Insomnia, nervous tension	Cold remedies, sinus medications, and sleeping medications (non-prescription) often contain aspirin; most use the antihistamines methapyrilene and pyrilamine. Pyrilamine has been shown to produce congenital deformities in animals.
PRESCRIPTION DRUGS:	
Amphetamines Nervous system stimulation; weight control and psychological dependence	Act as a stimulant on the fetus, heart malformations may occur. ***SPECIAL CONSIDERATIONS** Amphetamines should never be taken.
Antibiotics Bacterial infections, such as bladder infections.	**Streptomycin** Hearing Loss, problems of balance and dizziness, and kidney malfunction. **Tetracyclines** Slows baby's bone and teeth growth; results in discoloration of infant's teeth. These effects are especially noticeable in the second half of pregnancy. **Chloramphenicol** "Gray baby" syndrome; interferes with baby's breathing (especially when given during labor). ***SPECIAL CONSIDERATIONS** Antibiotics should be taken only if the risk of infection outweighs the drug risks. For example, women who have untreated bladder infections may develop serious kidney infections that can jeopardize the pregnancy.

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EFECTOS DANINOS DE SALUD AL TOMAR DROGAS DURANTE EL EMBARAZO

DROGA Y RAZON POR USO	EFECTOS EN EL FETO/ CONSIDERACIONES ESPECIALES
ALCOHOL Factores social y psicologico	El mucho beber puede causar defectos del corazon y malformaciones facial y de las extremidades. Ninos de madres alcoholicas probablemente al nacer son adicto y tienen que sufrir "cambios abnormales."
FUMAR CIGARILLO Factores soical y psicologico	Los hijos de mujeres que fuman cigarillos son mas pequenos y son propensos a mortalidad y morbosidad. El fumar es relacionado con los riesgos altos subido de mal formaciones del feto. Enfermedades congenitas del corazon, labio hendido, paladar hendido son mas comunes en hijos de madres que fuman. *** CONSIDERACIONES ESPECIALES:** El fumar tabaco evidentemente es danino a tu propia salud y a la del bebe. Tambien mientras mas se fuma, los peligros son mas grande y los riesgos son mas altos.
ANTIACIDOS Mal de estomago, acedia	Cuando la madre lo usa regularmente puede subir porcentages de defectos. *** CONSIDERACIONES ESPECIALES:** Pequena cantidades de vez en cuando para molestia extrema puede ser sano.
ASPIRINA Dolores y molestares	Atraso mental, abnormalidades en las extremidades, muerte del feto, el bebe puede perder sangre y otro defectos que comienzan a desarrollarse. *** CONSIDERACIONES ESPECIALES:** Aspirina es una ingrediente que se encuentra en varios medicamentos. Lea la etiqueta. Los efectos se suben cuando se toma la aspirina junto con el acido benzoico, que es una preservativo comun en comidas. Aspirina dado dos semanas antes de nacer el bebe, puede causar serio desangramiento en el bebe o en la madre.

LOS SUBSTITUTOS EN VEZ DE ASPIRINA Dolores y molestares	No es cierto los efectos de acetaminophen (el ingrediente en la aspirina substituto) en el feto. Estudios todavia no han probado su seguridad.
MEDICAMENTOS PARA CATARROS Y SENO Picazon en los ojos, nariz que gotea al consequencias de catarros.	Muchos de estos medicamentos contiene la aspirina, muchos usan las antihistaminicos methapyrilene y pyrilamine. Pyrilamine ha producido deformidades congenitos en animales.
MEDICAMENTOS PARA DORMIR Tension nerviosa, insomnio	
ANFETAMINA Estimulacion del sistema nervioso, control de peso.	Puede actuar como un estimulante en el feto, defectos del corazon pueden ocurrir. * **CONSIDERACIONES ESPECIALES:** Las anfetaminas nunca se deben tomar.
ANTIBIOTICOS Infecciones bacterianas, como las infecciones de la vejiga.	Streptomycin: Perdida del oir, problemas con el balance, mareos, y problemas en los rinones. Tetracyclines: Atrasa el crecimiento de los huesos y dentadura, puede resultar con los dientes descoloridos. Estos efectos se pueden notar especialmente en la segunda etapa del embarazo. Chloramphenicol: "bebe gris" sindrome. Puede afectar la respiracion del bebe (especialmente durante el parto). * **CONSIDERACIONES ESPECIALES:** Antibioticos solamente se puede usar cuando los riesgos de la infeccion son mas grande que los riesgos de usar la droga. Por ejemplo, mujeres que no se tratan las infecciones de la vejiga pueden desarrollar infecciones de los rinones mas graves y pueden poner en peligro al embarazo.

APPENDIX M

CORRESPONDENCE

March 13, 1990

Sarah Mack, R. N.
____
____

Dear Ms. Mack,

I watched with great interest the segment on the news last evening about a program you are implementing at your center with young pregnant mothers. It appears to be an innovative program that could reach many more young mothers. I commend you and the ______________________ for such an outstanding initiative. I was wondering if you could share some of the outcomes of your program with me.

As an early childhood educator and former ____________ teacher, I know how important it is to make those positive connections with parents and children at a very early age. Congratulations on being recognized for an outstanding program. Let's hope that the 1990's will continue to bring programs such as this to many more disadvantaged mothers and children.

Sincerely,

M.G.Z.
Coordinator of Field Services

DATE: ______________________________

DEAR

I thank you for agreeing to sponsor an expectant parent in the Prenatal Education and Support program. The donation is for the sum of $20.00. Your cancelled check can serve as a receipt for tax deduction.

Sincerely,

G.Y.
Program Director

Sarah Mack, M.A., R.N.
Health Specialist

July 5, 1989

Ms. Sarah L. Mack
Medical Coordinator
____
____
____

Dear Ms. Mack:

I am pleased to inform you that the Trustees of The George Gund Foundation have approved a grant of $5,000 (Grant Number _____) to _________________________ to begin a prenatal support program for pregnant mothers participating in the ___________________ program. This action has been taken in response to your proposal of April 13, 1989 and is made on the terms described below.

Based on our review of your proposal, we have established the enclosed payment schedule for your grant. Grant payment cannot be made until the copy of this letter which includes the signed acceptance form is received.

It is our understanding that grant funds will be used for staff, materials, transportation, and miscellaneous expenses involved with the pre-natal support program. Goals of the project are the early identification of pregnant mothers and subsequent linking with a pre-natal clinic; the planning and conduct of an expectant parent's educational program twice a month, and the provision of one and one-half hours of counseling per client; monitoring of the pregnant mother's health risk factors twice each month, with referral to physicians if required; and the reduction of the number of infants born prematurely or with low birth weight to the program participants.

Under the laws of our Federal Government relating to the Foundation, all grants must be used solely for educational, scientific, or charitable purposes. The objective of this grant, as indicated above and described in the background material you have provided, may be modified only with the Foundation's approval.

It is our understanding that ________________________ and _____________ has been determined to be a tax exempt agency described in Section 501(c) (3) of the Internal Revenue Code and is classified as other than a private foundation under Section 509(a) of the Code. If there is any change in this status and/or classification, please let us know promptly. In event of loss of tax exempt status under Federal laws, or a change in classification, no further expenditures of grant funds are to be made and any unspent grant funds are to be returned to the Foundation.

Would you please arrange for our Foundation to receive semi-annual progress reports, including financial statements of income and expenditures. Any correspondence sent to the Foundation regarding this grant should be addressed to __________________, Senior Program Officer, and should reference the __________ grant number. When there are press releases, photographs, and any published material about this grant and the work it has made possible, we would appreciate receiving copies.

We are pleased to be able to assist ________________________ in dealing with the problems of pregnant mothers participating in the ______________ program, and hope, with you, that it results in more favorable outcomes for both the mothers and their children.

If this letter correctly sets forth your understanding of the terms of this grant and there has been no change in the IRS status and classification of __________________________ as indicated above, will you please countersign the attached copy and return it to me.

Sincerely,

DB
Executive Director

JGS/dlm
Enclosure

April 21, 1990

Sarah L. Mack
____
____
____

Dear Sarah:

The Ohio _____ _____ ___________ is pleased to accept your workshop, A Prenatal Education and Support Program for _____ _____ for inclusion in our 1990 June Conference. We are in the process of blocking the days and times for the conference workshops and will notify you as soon as possible the specific date and time for your workshop.

Our training sessions are held on Tuesday, June 5, and Wednesday, June 6 and Thursday morning, June 7, so please hold those dates for your presentation at the conference and we will forward a detailed notice within 3 weeks.

If you have a preference of days and/or times, please call me at ___________________ at your earliest convenience so that I can make certain you get the date/time requested.

As promised, your registration at the conference will be complimentary. When your agency completes its registration for the conference, please have them include your name, and indicate "complimentary" on the form.

We are looking forward to our program this June, and to your participation with us. We have the promise of another highly successful June Conference and we are pleased that you will be a part of our success.

Sincerely,

________ __________
Director of Training and
Operations

APPENDIX N

RECAP OF PES SESSIONS

PES RECAP INFORMATION

PRENATAL EDUCATION AND SUPPORT PROGRAM (PES)

Staff Orientation

The purpose of the Prenatal Education and Support Program (PES):

1. To provide expectant women with education about pregnancy and give emotional support that will ensure the birth of healthy babies.
2. To assist expectant women in obtaining needed items such as food, items for themselves, unborn infants, and other family members.
3. To provide an opportunity to enjoy the course of pregnancy.

The review of the information on the Flyers (see Appendix L).

The Pre- and Post-Nutrition Assessment test taken.

The schedule; place and time for the meetings.

The nutritionist staff from the Maternal and Infant Care Program:

Reviewed the responses to the nutrition assessment pre- and post-test as related to the four basic food groups.

Free gifts given from the M & I.

Free gifts given from the PES program.

SESSION 1

The first session had four participants. It provided education about pregnancy and feeling good about it.

Individual Information packages were given to all who were in attendance.

Information in the folders:

- Welcome letters to the PES program.
- Name tags

- Pre- and Post-Nutrition Assessment
- Daily nutrition intake chart
- Book mark with a list of available resources

The Pre- and Post Nutrition Assessment was completed. The contents were reviewed by the nutritionists RDA. The nutritionists passed out gift packages with information about pregnancy. The participants were informed about the Women Infant & Child (WIC) and Maternal & Infant (M & I) programs and encouraged to sign up.

SESSION 2

"GOOD NUTRITION FOR MOMMY AND ME"

(Spanish version follows)

The bi-monthly meeting focused on good nutrition during pregnancy. The mothers were advised to remember to eat properly to feed the baby. A healthy weight gain is approximately three pounds a month or 25 to 30 pounds for the total pregnancy.

The nutritionist talked about the different ways to get in the basic food groups. If you do not like regular white milk you might try chocolate milk, ice cream, and custards.

A slide show was shown called "Inside my Mom--Baby's Viewpoint." It depicted how the baby viewed his mommy's eating habits.

The snack was tuna fish, carrot and celery sticks, tomato wedges, wheat and Ritz crackers, with apple cider. In keeping with the theme, the tuna was water-packed, the crackers were low sodium, and the cider was fortified with vitamins and minerals.

The gift for the week was a Teddy Bear.

SESSION 2 (SPANISH TRANSLATION)

"Buena nutricion para mama y el bebe"

"GOOD NUTRITION FOR MOMMY AND ME"

La reunion mensual a cerca de la buena nutricion en el embarazo. La madre es aconsejada a recordar comer adecuadamente para alimentar al bebe. El aumento de peso adecuado es de aproximadamente 3 libras por mes o 25 a 30 libras durante todo el embarazo.

Los nutricionistas hablaron acerca de las diferentes maneras de obtener los grupos basicos de alimentos. Si no te gusta la leche regular puedes probar con leche de chocolate, helado y natillas.

Un slide show que se mostrara, llamado: "Dentro de mi Punto de Vista del Bebe." Habla de como el bebe ve los habitos de comer de su mama.

El snack fue tuna, zanahoria y apio, tomates, galletas ritz y jugo de manzana.

De acuerdo con el tema, la tuna estaba empacada en agua, las galletas, bajas en sodium y el jugo fue enriquercido en vitaminas y minerales.

El regalo para la semana fue un osito.

SESSION 3

In depth discussion of medical terms with Obstetrician/ Gynecologist (see Appendix K).

SESSION 4

"You and Your Concerns"

Participants discussed and shared concerns with their peers and medical and counseling staff.

SESSION 5

Continuation of discussion of shared issues or concerns.

Counseling provided as needed in the group and one-on-one information discussed; considered confidential.

Support staff were:

Writer, Staff, and Graduate Counseling Student

SESSION 6

Tour of a Neonatal Intensive Care Unit

The PES group was welcomed by a Personal Relations staff, nurse, RN, social worker, and physician. The group received an introduction to the following:

Hospital's history - Geographical location
The various health and medical services
The population it served.

Visit to the Admission Unit
A visit to the Labor and Delivery Rooms
All of the equipment used was explained and demonstrated.
Hands-on experience was encouraged whenever possible.

Visit to the Neonatal Unit -- Observations:
Babies born before time
Approx. 10-12 newborns in the unit.

The PES group was informed that the babies were born before 9 months or over 37 weeks and weighed less than 5 pounds 5 ounces.

Status of the Babies Born Preterm:

Babies suffer from respiratory problems. Their lungs are not fully developed. These babies need:

1. To be kept in a special unit in an isolate;
2. Oxygen to help them to breath easier;
3. Special formula and to be fed by special devices; to be kept warm;
4. Need to be watched very closely because they could stop breathing or start bleeding;
5. Need medication to prevent infection.

Preterm birth can be prevented for the majority of babies if their mothers follow these steps:

1. Expectant women should not smoke or drink alcoholic beverages.
2. Expectant women do not "do drugs," especially "crack".
3. Avoid emotional stress factors and depression.
4. See a doctor once you think you are pregnant.
5. Eat the recommended diet daily as prescribed by your doctor and nutritionist.

Film Presentation: "Children of Crack".

SESSION 7

Continuation of the discussion of issues of babies seen in the Neonatal Intensive Care Unit.

Discussion:

Babies born to mothers using crack have serious problems when they start pre- and public school. They are not like normal children. These babies may have difficulty learning and getting along with other children. Sometimes, babies born to women who use crack and other drugs, including alcohol, are born with defects.

Women using drugs should tell their doctors.

The handouts given earlier on drugs were reviewed (see Appendix L).

Other issues discussed as a result of a baby born prematurely:

1. Financial cost;
2. emotional and physical drain on the parents and other family members;
3. frequent trips to and from the hospital to visit the baby;
4. the mother is torn between the care of the preterm baby at the hospital and other children at home;
5. The mothers often blame themselves for having a preterm baby.

Prevention measures repeated.

A practicing clinical psychological presentation. He discussed the stress and joy newborns bring into a family. The two variables are contrasted in the following table.

STRESS	JOY
Additional physical and mental exhaustion, mostly for the mother.	Lovable and cute
The frustration in trying to meet the needs of spouse and other children.	Siblings and spouses are elated at the arrival of a new family member.
Emotions are high for both parents.	If it is a boy, father and paternal parents are happy. The family's name will be carried on.
If the mother has a job and is on a leave of absence, the thoughts and frustration of returning to work leaving the infant with a baby-sitter.	The pleasure of being home with the new baby.
The additional financial expenses that come with a newborn.	The desire and attempt to purchase new items for the baby.

The selection of names is important in a child's life and upon becoming an adult:

1. Give your child a first and a middle name to ensure easy identification.
2. Select a name that both parents agree upon if possible.
3. Use names that reflect the family heritage.
4. Avoid names that are used for both a boy or a girl.
5. Avoid nicknames that depict low self-image; for example, "Peanut Head, Bo Bo" and "Fatty."
6. Avoid combining long first and middle names.

SESSION 7 (SPANISH TRANSLATION)

Discusion:

Bebes nacidos de madres que utilizan drogas, especialmente el crack, causan serios problemas cuando los bebes llegan a la edad escolar.

Ellos no son ninos normales, estos bebes podran encontrar dificultades de aprendizaje al igual que asociarse con otros ninos.

Algunas veces los bebes nacidos de madres que utilizan el crack y otras drogas, incluyendo el alcohol, nacen con defecto.

Las mujeres que utilizan droga deben informarselo a sus doctores.

Las volantes sobre drogas fueron revisadas y entregadas anteriormente.

Otros temas discutidos como resultado de bebes nacidos prematuramente:

1. Costo financiero
2. Consuelo emosional y fisico a los padres y otros miembros de la familia.

3. Viaje frecuente al hospital para visitar a los bebes.

4. La madre es llevada a las unidades de bebes prematuros del hospital y otros ninos en casa.

5. Las madres siempre se culpan a si mismas por tener bebes con problemas.

Medidas preventivos se han repetivo.

Una Presentacion logica y clinica

Se discutio sobre las tensionas y regocijos que los recien nacidos acarrean a la familia.

La seleccion de nombre es importante en la vida del nino al igual que en su etapa adulta.

1. Dele a su bebe un primer nombre y un segundo nombre para asegurarse facil identificacion.

2. Seleccionar un nombre que ambos padres hallan elegido.

3. Usar nombres que reflejen la herencia de la familia.

4. Evitar usar nombres que sean para ninos y ninas.

5. Evitar sobrenombres

6. Evitar conbinacion de nombres largos.

Tensiones	Regocijo
Ayuda emocional para la madre La frustacion de confrontar necesidades de la esposa y los otros ninos.	Amable y cuidado Llegada de un nuevo miembro a la familia.
Emosiones fuertes para ammbos padres. Si la madre tiene un trabajo y esta incapacitada por maternidad los pensamientos de volver a su trabajo la agovian de tener que dejar al recien nacido con una ninera	Si es un nino el padre estara contento porque llevara el nombre de la familia. El placer de tener en casa al nuevo bebe. El deseo de comprar nuevos cosas para el bebe.

SESSION 8

DRUGS

Drugs that are ingested or inhaled readily go through the placenta to your baby. This includes drugs that are applied to the skin or mucus membranes.

Harmful Drugs

Alcohol
Cigarette smoke
Antacids
Aspirins
Aspirin substitutes
Cold remedies and sinus medication
sleeping medications
Rubella virus (measles)

Effects on the fetus

Mental Retardation
Small brain and head
Blindness
Deafness
Heart defects
Death

Prevention

Do not use drugs, especially "crack".
Avoid people who have measles.
Have a rubella titer test to determine your immunity level.
Take only medications prescribed by your doctor.
Do not smoke.

SESSION 9

LEGAL AND PHYSICAL ISSUES ON THE UNBORN CHILD

Practicing Attorney

Parents are responsible for the care of their unborn infants.

If the pregnant woman takes drugs during pregnancy, the law will take the baby after it is born. The child has rights and can not be subject to the "Child Endanger Statue Law."

Child must be treated like a human being, which means:

The parents need to provide the basic needs, such as food, clothing, and shelter.

No person is allowed to create a risk of harm to the child.

All punishments need to be reasonable.

The attorney's telephone number ________________

If any one needs legal advice, please call.

SESSION 10

HOW TO HELP YOUR CHILD BECOME A SUCCESS IN SCHOOL

Presentation given by Early Childhood Educator (teacher)

INTRODUCTION

You can make a difference. Parents, you have a right to demand for your children, the best our schools and colleges provide. But your right to a proper education for your children carries a double responsibility. As surely as you are your child's first and most influential teacher, your child's idea about education and its significance begins with you.

You must be a living example of what you expect your children to honor and emulate.

Moreover, you bear a responsibility to participate actively in your child's education. It is you who can develop within your child, the feeling and attitudes that will make for success in and out of school.

Creating and maintaining a favorable educational environment, and your willingness to give of your time in creating this environment, will have many positive effects upon your child.

GAMES

Experience in the form of games and play will greatly influence his or her intellectual ability later on. It has been said that if certain kinds of experiences are not provided for a baby during the first two years of his life, the chances of his reaching the intellectual potential he was born with are probably reduced.

First they will help the baby develop basic skills, such as focusing the eyes, coordinating the eyes and hand, distinguishing differences among identical objects. These skills will have an immediate pay-off in fun, and later pay-off in the ability to perform more complicated jobs such as reading and thinking.

The basic principle is that you should provide the infant with many interesting opportunities to learn, to explore, to interact with you. There are activities that will bring fun to both of you and develop the baby's confidence in himself and you as a parent.

These games start early in life while the baby is flat on his or her back. They are designed to help use new-found abilities to make sounds and move the head and hands at will. These early sounds are the first step toward language. First, the infant enjoys it. Second, it needs this encouragement.

The rattle game is designed to foster the coordination of the baby's senses, eyes, and ears with the ability to move.

Mobiles over the crib should be bright, bold colorful pictures hung where the baby can see them.

At this time, talk to him. The sound of your voice, its rhythm and pattern, will in the long run contribute to language learning.

LANGUAGE LEARNING

Oral language is developed by surrounding the child with a rich oral environment--for example, reading stories and poetry to your child daily and talking with your child individually and in family groups. Encourage your child to talk to you, so that he or she will learn how to express thoughts orally. The infant's listening skills can be improved with the use of tapes, stories, or records as rich development models.

Understanding oral language is related to the mental development of your child. The words that your child uses represent ideas and concepts within the child's realm of knowledge.

Children can understand some detailed directions such as, "Put your toys on the bottom shelf."

In their play, they act out concepts like on or off, over or under, many or few. Many parents play these games with their child. However, they must have patience with the child, and realize that all children develop at different stages.

Learning is still firmly based on first-hand experiences. If you say red, or you say circle or square, or rattle off the alphabet, it may have no meaning to the child 2 or 3 years old. The best teaching at this age is to give children wide experiences in the real world, appropriate material to play out these experiences, and a wide variety of books. Children, like all of us, learn best what they teach themselves. They will take from all experiences, in life or in books, what they can understand.

Early and Middle Child Educator

SESSION 11

The PES group members arrived at the center for a meeting which was not officially scheduled.

SESSION 12

DENTAL HEALTH AND EDUCATION PRESENTATION

Each participant received an oral examination. The proper techniques for brushing and flossing were demonstrated. Expectant women should visit their dentist for routine check ups.

Emphasis was placed on the importance of parents preparing children for dental visits.

Foods high in calcium were discussed (milk & milk products)

Expectant women who can not drink milk or do not like it should talk to their doctors about supplements containing enough calcium to meet their specified requirements.

Teething

Teething is a difficult time for babies. The new teeth are pushing their way up through the gums. The gums are often sensitive, sore, and reddened.

Allow them to chew on a teething ring or rub gums lightly with your fingers. If baby continues to be fretful or develops a fever or diarrhea, contact your doctor.

SESSION 13

MEDICAL SCREENING FOR YOUNG CHILDREN

Pediatrician

Medical screenings are essential. All should have blood pressure (BP) read. Many children have elevated BP. Children who have high blood pressure can have the following:

Lead Poisoning - comes from chipped paint & diet.

High lead level causes brain damage and/or seizures.

High lead level should be checked annually.

Newborn Infants

Encouraged the mothers to read printed material, then discussed the growth and development of their babies. They were told not to compare their baby's growth to their friends' or relatives' babies. Once a woman has a premature baby, she is at high risk of having other babies before time.

SESSION 14

Evaluation of the PES program by the participants
The planning of future sessions.
Education and counseling where needed.

SESSION 15

Party and round up; pediatric nurse and dental consultant; return of former speakers and participants.

APPENDIX O

TELEVISION/MEDIA COVERAGE

(Press Release)

PRENATAL EDUCATION AND SUPPORT (PES) PROGRAM

becomes a part of _________ at _________ ______.

Quality and continuous prenatal health and education can never be overly emphasized for the betterment of expectant mothers and their unborn infants.

In September 1989, a Prenatal Education and Support Program was funded by the George Gund Foundation to service 25 expectant parents. The objective of the program was designed to enhance the quality of prenatal education to parents and to provide emotional support during their pregnancy. In other words, the PES was not to detract from existing services but to augment them.

The criteria for admission is that the expectant mother must have a preschooler enrolled in _________; and be in her first or second trimester of pregnancy. They are encouraged and expected to attend the sessions scheduled every other Monday, unless they have complications, have a medical appointment, and if bed-rest or limited activities is ordered by their attending physicians. The duration of each session is one and one-half hours long.

The overall participation of the participants have been tremendous. The following topics have been presented:

> Nutrition, with a film presentation for expectant mothers and their infants (Maternal and Infant Staff, Metro General Hospital).
>
> Human Anatomy and Psychology as related to pregnancy, child bearing, and birth. (Well-known Gynecologist & Obstetrician, Cleveland, OH.)
>
> Daily practice of good, sound health habits during pregnancy. The effect of drugs on the expectant mother and the unborn fetus (Agency's Medical Component Staff).
>
> Growth and development during early childhood (Agency's Certified Early Childhood Educators). The mothers were highly receptive to the information on early childhood growth and development; it provided insight in understanding what to expect of young children's behavior.
>
> Tour of the Labor, Delivery, and Neonatal Intensive Care Unit (Metro General Hospital & Staff).

To facilitate the participants' attendance, the following bonuses were added:

1. Baby sitting services
2. Transportation
3. Nutritious snacks
4. Baby items are given to help prepare for the infant's needs after birth.
5. Items that the mothers can use during their hospital stay.

After the birth of each baby, the mother receives a gift for the infant and a cash donation for herself.

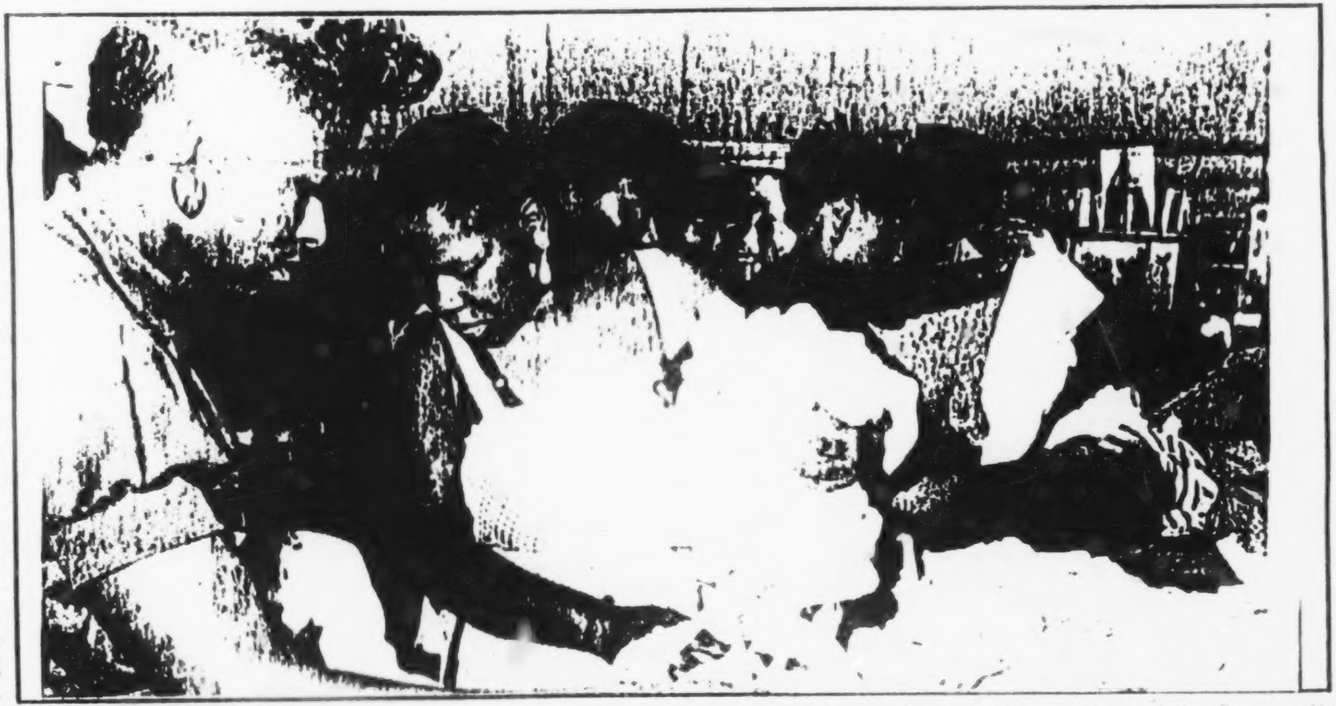
Unfortunately, many expectant mothers who sought admission to the program did not qualify for two reasons. First, they did not have a child enrolled in the ______ ______________ ________ Program. Second, they were already into their third trimester of pregnancy.

Several positive efforts of the PES Program are that, the group seems to be enjoying the support of their peers, educational concepts that are presented by various presenters, donated gifts are presented for the babies (before and after birth) and mothers. Questions are asked; information and experiences are shared by participants in the PES group.

Thursday May 17, 1990

Prenatal Care Offered to Head Start Moms

By SUSAN B. GRIFFITH
Call and Post Staff Reporter



EXPECTANT MOTHERS receive many baby gifts as part of the Prenatal Education and Support Program through the Community United Head Start & Day Care Center, Inc. The prenatal program provides mother of preschoolers with information about pregnancy related topics.

Ciquita O'Neal credits being alive today to the prenatal care and information received through the Prenatal Education and Support Program of Community Head Start & Day Care, Inc.

On March 25 she gave birth to Ty'quatta, who weighed in at one pound and 13 ounces and decided to make an appearance at 27 weeks into the pregnancy.

The mother of a preschooler stressed how important visiting the doctor is: "Every pregnancy is different." O'Neal's first child made an uneventful and healthy entrance into the world, but her experience with carrying her daughter was quite different.

Without the visits to the doctor, O'Neal said, "We both may have died."

O'Neal suffered from a rare condition called the HELP syndrome, which results in liver failure, toxemia and hypertension.

Mom is healthy today, and baby has gained 10 ounces with a chance of going home from the hospital around June 20th, which would have been O'Neal's due date.

As a mother with a child in the Community United Head Start program, she was one of 25 mothers eligible to attend the prenatal classes under the guidance of registered nurse, Sarah L. Mack, who has organized the classes for expectant mothers with preschoolers.

L. Mack noticed that many mothers were having premature babies. Due to their early arrival, these children had special medical problems and impaired vision. Talking to the mothers of these children, she found many had not visited the doctor during their pregnancy.

At that point she decided to get information to expectant mothers of the Head Start preschoolers.

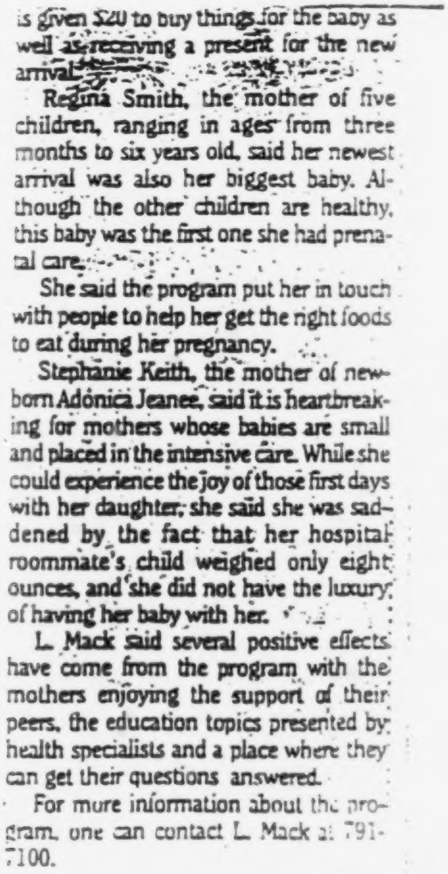
Funded by the Gund Foundation, the program started, last September, to educate mothers about nutrition, human anatomy and psychology as related to pregnancy, child bearing and birth, healthy habits during pregnancy, growth and development during childhood as well as give them a tour of MetroHealth Hospital's labor, delivery and neonatal intensive care units.

The program will continue through the end of August.

Since the program started in the fall for mothers in their first or second trimesters of pregnancy, the program participants now include ten moms who have brought with them their healthy babies for everyone to see.

The participants meet at the Community United Head Start on E. 46th Street in the center of the CMHA projects.

L. Mack has also provided mothers not only with helpful information but with baby sitting services during meetings twice a month, transportation, nutritious snacks and items to make a mother's hospital stay comfortable and for the baby. After the baby is born, each mother



is given $20 to buy things for the baby as well as receiving a present for the new arrival.

Regina Smith, the mother of five children, ranging in ages from three months to six years old, said her newest arrival was also her biggest baby. Although the other children are healthy, this baby was the first one she had prenatal care.

She said the program put her in touch with people to help her get the right foods to eat during her pregnancy.

Stephanie Keith, the mother of newborn Adonica Jeanee, said it is heartbreaking for mothers whose babies are small and placed in the intensive care. While she could experience the joy of those first days with her daughter, she said she was saddened by the fact that her hospital roommate's child weighed only eight ounces, and she did not have the luxury of having her baby with her.

L. Mack said several positive effects have come from the program with the mothers enjoying the support of their peers, the education topics presented by health specialists and a place where they can get their questions answered.

For more information about the program, one can contact L. Mack at 791-7100.

Media Coverage

Urban News, Council for Economic Opportunities in Greater Cleveland. February 1990.

Video:

Prenatal Education and Support Group, WJW-TV Channel 8, 6 PM News, March 12, 1990.

APPENDIX P

PRENATAL EDUCATIONAL FILMS

PRENATAL

Spanish Titles in Parenthesis

Title of film: Prenatal Care (Cuidado Prenatal)

Length of film: 25 minutes

Where to order: Ohio Department of Health, Division of Health
246 North High Street, P. O. Box 118,
Columbus, OH 43266-00118

Grade Level: All levels Race/Ethnic Group: W-B Couples

Recommended groups for use: Visually and hearing impaired, teachers, parents, teens, ministers (good for training).

Summary: Good message about early and continued prenatal care. Specifically discussed: Doctor care - symptoms of pregnancy, physical exam; Precautions: (medicines) drugs, alcohol, smoke, German measles, pain, severe cramps, bleeding, water, nutrition, exercise; normal changes

Title of film: A Family Approach to Prenatal Care
(Enfoque Familiar del Cuidado Prenatal)

Length of film: 27 minutes

Where to order: Wyeth Laboratories, Philadelphia, Pa 19101

Recommended groups for use: Churches, street clubs, all

Summary: Prenatal care from conception to delivery. Very detailed.

Title of film: Anatomy & Physiology of Pregnancy
(Anatomia y fisiologia del Embarazo)

Length of film: 10 minutes

Where to order: Ohio Department of Health Promotion,
246 North High Street, P. O. Box 118
Columbus, Ohio 43266-0118

Grade level: 6th Race/Ethnic Group: W

Recommended groups for use: All groups

Summary: Graphics used to explain reproduction and female anatomy for pregnancy. Demonstrates fertilization, cell division, and uses proper names for body parts.

Title of film: Emotional Aspects of Pregnancy
(Aspecto Emocional del Embarazo)

Length of film: 25-30 minutes

Where to order: Cuyahoga County Library

Recommended groups for use: Teen moms/pregnant women

Summary: Discusses mom and dad's feelings about pregnancy.

Title of film: Born Hooked
(Nacido Dependiente)

Recommended groups for use: All

Where to order: March of Dimes

Summary: Babies born to methadone and heroine mothers. Explains withdrawal for infant and need for special care. Reasons mothers don't come in for prenatal care, fetus of pregnant addict. Shows infant going through withdrawal.

Title of film: Alcohol Crisis For The Unborn
(Crisis de Alcohol para el Feto)

Where to order: March of Dimes

Recommended groups for use: Teens, adults

Summary: Explanatory, graphic pictures, simple language. Slow growth of child, physical and brain mild-moderate-severe mental deficiencies, shows child in action.

Title of film: Fetal Alcohol Syndrome
(Syndrome de Alcohol en el feto)

Length of film: 15 minutes

Where to order: Cuyahoga County Library

Recommended groups for use: Educators, expectant parents, laymen, biology class

Summary: The affects on the child of alcohol during pregnancy.

Title of film: A Physical Examination (Reconocimiento medico)

Length of film: 15 minutes

Where to order: Cuyahoga County Public Library

Grade level: Elementary/Pregnant women

Summary: Children having their first physical. Good for promoting physical examinations for prevention purposes.

APPENDIX Q

DOCUMENTATION OF PERMISSION TO REPRINT

Meredith
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- Magazine
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Richard L. Rundall

June 4, 1990

Ms. Sara Mack
3636 East Blvd.
Cleveland, OH 44105

Dear Ms. Mack:

As we discussed on the telephone recently, you have permission to include pages 232 and 245 of the Better Homes and Gardens WOMEN'S MEDICAL GUIDE in your doctorial report as well as permission to translate them into Spanish for use in your child development classes.

Permission is granted under condition that all usages include the notation "© Meredith Corporation. All Rights Reserved." And that none of the above uses will be for resale to consumers or other interests.

Thanks for your inquiry and best wishes in your endeavors.

Sincerely,

Richard L Rundall

Richard L. Rundall

RLR:mc
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